







Digitized by the Internet Archive  
in 2022 with funding from  
University of Toronto

<https://archive.org/details/31761114666464>











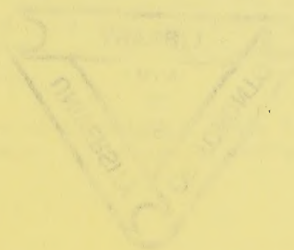
CA20N  
XC12  
-578

S-13

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

INDEPENDENT HEALTH FACILITIES ACT, 1989

MONDAY 14 AUGUST 1989





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)  
VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)  
Allen, Richard (Hamilton West NDP)  
Beer, Charles (York North L)  
Carrothers, Douglas A. (Oakville South L)  
Cunningham, Dianne E. (London North PC)  
Daigeler, Hans (Nepean L)  
Jackson, Cameron (Burlington South PC)  
Johnston, Richard F. (Scarborough West NDP)  
Owen, Bruce (Simcoe Centre L)  
Poole, Dianne (Eglinton L)

Substitutions:

Dietsch, Michael M. (St. Catharines-Brock L) for Mr Daigeler  
Fleet, David (High Park-Swansea L) for Mrs O'Neill  
Hosek, Chaviva (Oakwood L) for Mr Beer  
Kozyra, Taras B. (Port Arthur L) for Ms Poole  
Philip, Ed (Etobicoke-Rexdale NDP) for Mr R. F. Johnston  
Reville, David (Riverdale NDP) for Mr Allen

Clerk: Decker, Todd

Staff:

Drummond, Alison, Research Officer, Legislative Research Service

Witnesses:

From the High Park Youth House:  
Wine, William, Executive Director

Individual Presentation:

Lamont, Jim

From the Dialysis Management Clinics Inc:

Holtzer, Carol, Director  
Holtzer, Igal, Director  
Tantalo, Franca, Director

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriole L)  
MacMillan, Dr Robert, Executive Director, Health Insurance Division  
Sharpe, Gilbert, Director, Legal Services Branch  
Gotlieb, Rebecca, Counsel, Legal Services Branch  
Barnes, Marsha, Manager, Independent Health Facilities  
Mauro, Debi, Executive Director, District Health Council Program



LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 14 August 1989

The committee met at 1409 in committee room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: Members of the committee, we will call the meeting to order. As the standing committee on social development, we have before us Bill 147, An Act respecting Independent Health Facilities. We were scheduled to begin at 2 pm.

I just want to inform the committee that three groups that had been scheduled to appear this afternoon phoned and cancelled their appearances without asking to be rescheduled. I will ask the clerk to report on what those three groups are.

Clerk of the Committee: They are the Ontario Public Health Association, the Association of Ontario Health Centres and the Eastern Health Area Community Advisory Board which cancelled on Friday afternoon.

The Chairman: That leaves us with a shorter afternoon than we had anticipated. I have some organizational items to raise, but I think I will wait until we have full representation of all parties to raise those, later in the afternoon. We will begin with the hearings at this time.

Our first delegation is the High Park Youth House and representing that organization is William Wine, executive director. Welcome to the committee.

Mr Wine: Thank you.

The Chairman: You may be seated. You have 15 minutes for your presentation and committee members may have questions as part of that. You may proceed.

HIGH PARK YOUTH HOUSE

Mr Wine: I intend to make my submission as brief as possible. Basically, I outlined on one page the essence of the ideas I have.

Previously, last year, I submitted an application for a program, and thinking about it further, it struck me that the present piece of legislation, the Independent Health Facilities Act, would act as enabling legislation that would permit a clinic to be formed for the treatment of outpatient persons with drug or alcohol problems.

Basically, when I talk about "drug," I use it in a fairly generic way to include any addictive disorder; for example, coffee, tobacco, alcohol and all



of the things we call drugs that are either prescription or nonprescription drugs.

I have given you this written material. What I intend to restrict myself to today is basically that I envision the proposal I have outlined, as I understand it and I am desirous of some feedback from this body, as being something that could be subsumed under the rubric of an independent health facility. In other words, I have experience in trying to get outpatient treatment for young offenders who I may refer to the Donwood Institute or the Alcoholism and Drug Addiction Research Foundation. But somehow, whenever I have a person who needs treatment, the admission criteria are such that I can never get that person into a program at the time that person needs treatment. In essence, by the time the person has served his open custody order or his probation order, then his number may come up, as it were. I feel that outpatient treatment for this category of person, as well as private patients, is the treatment of choice rather than an inpatient stay.

I worked for several years as the director of the group therapy department at the Donwood Institute. Basically, there, the program was at least four weeks in length, and in addition to the Ontario health insurance plan payment, they had to pay some money on their own. My fear always in that course was that staying in an institution, in and of itself, creates a kind of institutionalization syndrome, so I became more involved with the outpatient part of that facility. This was a way that would not stigmatize or role label a patient as much as the inpatient part.

The first bit of feedback I want to get from you is whether I am correct in my presumption that an outpatient facility such as I describe, and you may want to ask me more questions about it, would come under the rubric and whether a proposal could be entertained at some point when this bill becomes law that would enable a group of physicians to get together with other staff and run a program.

What I have documented, and there is further documentation and you may be privy to some of it that I am not, is that, first, there are needs in this area and the needs are, in fact, severe. Second, the needs have not been met by existing services, specifically in the catchment area of Metropolitan Toronto. Third, the treatment I propose as an outpatient treatment centre is important and necessary. Fourth, last but not least, is the fact that this form of treatment would be very cost-effective.

The hub of the treatment program, in essence, would be group therapy, although persons coming into the program could receive any other form of individual psychotherapy or nutritional counselling or even, in certain cases if it were appropriate, acupuncture, which has been touted as a form of treatment for addictive disorders. There is a Dr David Lam who I understand has been in touch with your ministry. He is probably the most prestigious acupuncturist in Ontario. He is willing to be a consultant to this clinic, and several physicians he has trained under his tutelage.

I have a neurological consultant, Dr Peter Carlen, who is the chief of the neurology department at the Addiction Research Foundation as well as the Toronto Western Hospital.

As I say, the hub of the program would be the formation of groups. The persons would get individual therapy and see all the different staff in this clinic and then we would form a group of between eight and 12 people. Then we would wean off a group and form another, so we would have three concurrent



groups. Basically, depending on the size of the facility, the patient load, the number of staff or all three, we could have three or six or 12 concurrent groups, each with a population of eight to 12 persons meeting on a twice-a-week basis.

I envision, based upon the demands in this catchment area we are talking about, that we could fill the program to capacity on the first level of three concurrent biweekly groups in three months. I envision that the cost of treatment would be one third to one sixth the cost of residential treatment for the same affected individuals if that were required. The difference in the costing there depends on how many concurrent groups would be running simultaneously. If we had six or 12, then it would certainly be more efficient, because I would be able to get more use of the manpower I had available.

In my own humble opinion, this legislation, if it were passed, would be a very powerful piece of enabling legislation that would allow treatment for this category of people without subjecting them to the institutionalization and stigmatization of having to be in a residential inpatient program. It would be innovative in the sense that this would be a treatment program, not simply a sort of social peer situation or counselling situation. This would be actual medical treatment.

I have with me today a person who could serve as the prospective medical director of this facility, Dr Sheldon Wagner, who is seated over here. If you have some questions you wish to direct to him, he may be available to answer them as well. I do not want to go over the time, although you assure me that there are some cancellations.

At this point, I will end my submission. I have something I could hand around and whoever is the most interested in it could keep it as a gift from myself, which gives some background to this matter.

Interjections.

Mr Reville: Perhaps I am going through the wrong--

Mr Jackson: I think you could best use it in your caucus at the moment.

Mr Reville: I wonder what that means.

The Chairman: Thank you very much for your presentation and for leaving time for questions from committee members, starting with Mr Reville.

Mr Reville: I just want to comment that your proposal sounds like an interesting and useful proposal, but it is difficult for individual members of the committee to answer the questions you pose, as I read Bill 147. You should be aware that I am an opposition member and perhaps I do not read it with as much delight as a government member might.

This is basically procedure-centred legislation, and the procedure your proposal would fall under would be a therapy kind of procedure that can be delivered as an insured service. To that extent it might be possible to fall within the ambit of the legislation. You would have to go through the rigmarole of hoping that a proposal call would come out, and then you would apply.

It might be more useful, Mr Chairman, if the minister wanted to respond to the question that is posed quite directly by this deputant.

Hon Mrs Caplan: Yes. Thank you. I am going to call on Bob MacMillan to answer specifically the question that was asked, but it is my sense that in fact the interpretation that this as a procedure-specific piece of legislation is not factual. This is a service. The operational part of the legislation responds to service need and allows for the expansion of services to be provided in alternative settings. The procedures for how that is accomplished are set out in the bill.

I am going to ask Bob MacMillan to comment on one of the advantages of the bill as it relates to the flexibility in expansion of community mental health programs.

1420

Dr MacMillan: I think Mr Reville is correct in identifying that for the most part the bill will address, certainly in the grandfathering phase, procedures that are being done, usually surgical, some diagnostic. Notwithstanding that, the wording of the legislation is such that it certainly is broad enough to include any insured services, because the facility fee is based on a diagnosis of supporting an insured service. Psychiatric care or counselling is certainly an insured service. In most programs that deal with drug addiction in particular, the psychiatric service is rendered.

The problem has been that traditionally in the community there has not been a mechanism for funding, other than physician services. All the other mental health workers that have evolved over the past decade and more to take an active role in treating such patients were never funded in a way that was as easy as for physicians to receive funding. In fact, several years ago any further additions were denied and we have been living in a vacuum, being able to fund such professionals in an institution but not having a funding mechanism in the community.

If, for instance, a proposal came forth from a group that was looking towards expansion of drug addiction programs and there were physician services for which auxiliary fees were needed in order to deliver a more comprehensive program, I would think this would be appropriate, but if a district health council believed it was important in its area and if the ministry concurred that it was needed, and possibly the cost-efficient factors you have indicated would be more economical to deliver it in a community setting, there would be nothing that would exclude that consideration from this legislation.

Hon Mrs Caplan: It is my understanding that you are not presently operating today. Is that correct?

Mr Wine: I operate an open custody facility for adolescents and I would say fully about 80 per cent of the youth in the Metropolitan Toronto West Detention Centre, the Metropolitan Toronto East Detention Centre or the Don jail have drug problems. But I see them on a residential basis. At any given time, I have 14 or 16 of them in my custody. I may refer them to different physicians, but there is no ongoing group therapy that I can send them to and they do not meet the criteria of the Addiction Research Foundation and they are too young for the cohort at the Donwood Institute or the Bellwood Health Services.



I do not have enough of them in captivity at any one time who have the same kind of presenting symptomatology to form a group out of them. So at the moment I do not have an outpatient group formed out of all these types of people, but I would not restrict this proposal just to young offenders. It could be older neurotic outpatient persons who could come to the same centre and receive group therapy from the same group of staff.

In fact, in some instances, mixing the groups up does help because instead of sort of seeing your own face in the mirror in the group, you are exposed to a different type of pathology which tends to liven things up a bit.

Mrs Cunningham: What would be different? Why can you not start a group now?

Mr Wine: I do not have enough people who need group therapy. Basically, what I would envision here would be a mailout to physicians on a list and all the hospitals in the area, all the group home operators and operators of open custody facilities and children's mental health centres and the superintendents of the various detention centres to make them aware of the existence of such a centre.

I know there is a case load out there in the catchment area that is sufficient for this, but the nonphysician personnel component of such a clinic at the moment cannot attract any sort of funding. If the response I am getting from Dr MacMillan bears out and down the road, six months from now or a year from now, there is a proposal which is supported by the ministry that can attract such funding, then a relatively untrained person can be trained to be a group therapist. In other words, a person with an honours BA in psychology, under the supervision of a psychiatrist, can learn quite a lot about what you need to do without having to spend nine years of his life going through medical school, internship and psychiatric residency. That is where the cost savings would figure in, but the issue there would be in finding people who have the aptitude who do not necessarily have a psychiatry residency completed.

Mrs Cunningham: You answered my question by saying that most of the people who would be clients are now in residential care and the second part of your answer was that you could not set it up now because there is no funding mechanism unless you have a psychiatrist to operate his own clinic.

Mr Wine: I would that is correct, that some of them are in residential treatment, but people who are not in residential treatment who require treatment and cannot get it—I do not know if you have ever been with somebody who is trying to get some form of either inpatient or outpatient service at the Alcoholism and Drug Addiction Research Foundation. The waiting list is just an eternal process for these people.

Mrs Cunningham: I am very much aware of it. What I get, though, in response is that basically you have to have the psychiatrist in order to get the funding. I am correct on that, am I not? If clients were to come into my office, in a political office right now as I have and others do as well, parents who are seeking help for their child who has been sent home from the hospital or has been sent out of some institution and he is in the community and they are still not coping, they want some psychiatric help for the young person under the age of 18, we do not have enough adolescent psychiatrists. I just got off the phone now. Somebody phoned me this morning and said: "That is the real issue. There aren't enough adolescent psychiatrists." So you would have to find yourself some. You obviously have.



Mr Wine: I have one in tow here.

Mrs Cunningham: Lucky you. You should not go very far, because I mean you just walk outside that door and there are 5,000 young people waiting to see you. There are lots of people wanting to see adolescent psychiatrists in Ontario. I have asked the question before and I am just not sure. I hope you can get this started. Are you aware also of the fact that you have to go through some kind of process and be chosen and supported by the community, in a sense, by the health council. That is how the projects will be—

Mr Wine: Yes.

Mrs Cunningham: And that is not a concern? That is something you have done, you have been there and they recognize it.

Mr Wine: No, I look forward to that. If this enabling legislation does move through, then I could look forward to doing that without any problems.

Mrs Cunningham: Then the second part is if the funding is available.

Mr Wine: That is correct. Most of the people in this category, or many of them, do not have enough funds to pay out of their pocket for this kind of specialized service, so if it would become an insurable service and there being a scarcity or a rarity of adolescent psychiatrists—I am a psychologist and we would be part of the team—we would basically be able to spread ourselves around more. Instead of seeing one person you could see 12 people concurrently, so you would be able to treat more people, in essence.

Mrs Cunningham: So the real saving to Ontario on this one is that instead of young people having to stay in the hospital or in care they could be home in the community and getting outpatient care.

Mr Wine: That is correct.

Mrs Cunningham: That is the only saving, because people are having to pay right now for the services they are getting in hospital, correct? And it is expensive.

Mr Wine: That is true.

Mrs Cunningham: That is where you are trying to tell us this is a cost savings then.

Mr Wine: That is correct, and that we would train persons who do not have medical training to work under the supervision of our psychiatrist and medical director to perform the service. That would again be a far more effective and cheaper way of providing the service than having the service exclusively provided by the certified psychiatrist.

Mrs Cunningham: Who cannot provide the service now because there are not enough of them.

Mr Wine: That is correct.

Mr Fleet: I will leave aside the issue of the bill because I think that has been responded to. The proposal you have is interesting. Your current location on Gothic has occasionally been a controversial one, with an Ontario

Municipal Board proceeding and what not, and I was not quite clear from what is "here in writing and what you said whether you anticipated converting your existing operation if you could get what you wanted, or are you talking about an add-on, because you have also got a reference to 33 Russell Street as a facility centre. I am not quite sure what you physically imagined would happen.

1430

Mr Wine: Thank you. I would have kicked myself if I had left here and not asked the other additional question I had written down here and had forgotten to come out with. What type of municipal zoning requirements would need to be in place for such a facility, if it were set up, to operate in? I do not know, for example, if that property at 32 Gothic Avenue, which had been a private hospital for 80 years of its life but then became a nursing home and then became a residential treatment centre, could sustain this.

I do not know what the requirement would be, whether it would have to be C3, R3, Z3, R4 or Z4. I do not have any data to dovetail what this provincial enabling legislation would mean to the municipal authorities.

The Chairman: It is an interesting question.

Mr Reville: Quite frankly, the answer is nothing. The zoning question is resolved by the municipality where it properly lies.

The Chairman: That is right. It would vary from municipality to municipality.

Mr Fleet: But even physically; I am wondering whether you anticipate that you would have to do something physically to the property.

Mr Wine: Oh, no, that is a dedicated population; that captive population has been there for 14 years and I could happily see it staying there for another 14 years. It would mean acquiring some other type of property that would be more suitable.

The Chairman: We are getting beyond the scope of the purpose of this hearing.

Mr Fleet: That may be, but it is still very interesting and I was particularly interested, of course, because it is in my riding.

The Chairman: I thought that might be why you asked.

Mr Fleet: Certainly there seems to me to be a need to try to provide more effective services. I am not necessarily convinced it would be a money saver to the ministry. I suspect it is a question of providing additional services to people still in need but who have a need which may not currently be being met as fully as one might desire. It seems to me that it is difficult to go through the addiction research foundation. The Donwood Institute, I guess, would be the only other place that people really get sent to, and for youth it is a particular problem. There still may be a question of willingness, from the public's point of view, to pay for that.

We continually see problems of people being incarcerated who are clearly in need of some kind of counselling and medical assistance and who do not get it or do not get it adequately. So I am sensitive to the motivation that would lead you to come up with this rather imaginative proposal. It seems to me it

is indicative of larger problems we have with people who go through the correctional system in one way or another, at all ages.

Drug abuse, using the word "drug" in a broad sense, as you have defined it, is surely a major problem that contributes to a lot of the criminal activities that people then get convicted for. I am interested in the ingenuity that you have applied to the proposal. I am not sure how it necessarily fits under the bill.

The Chairman: Is there a question?

Mr Fleet: I am indicating my interest, on the record, for which I thank the committee.

The Chairman: Thank you for coming before the committee. You have presented us with your perspective on the legislation and raised some interesting questions.

Mr Wine: Thank you for having me.

The Chairman: Our next presentation is by Jim Lamont. Is he here? Mr Lamont, welcome to the committee.

Mr Lamont: It is the first time I have been here in the Parliament buildings and I have lived in this city all my life.

The Chairman: Welcome to the standing committee. You have approximately 15 minutes for your presentation and members of the committee usually like it when you leave some time for questions.

JIM LAMONT

Mr Lamont: I believe what we are talking about here is setting up medical centres similar to the health maintenance organizations down in, say, Florida. Is that correct?

Hon Mrs Caplan: No. I guess if you were to compare them with what exists today south of the border, they would be more like the urgicentres or surgicentres. Actually, we had a list of them. Bob, do you remember a few more of the other types?

Dr MacMillan: I think those are the commonly used terms: urgent care centres or surgicentres which are off-site from a hospital.

Mr Lamont: In other words, these would not be known more or less as medical centres then, in the loose term, where somebody would go there for assistance.

Hon Mrs Caplan: These are very specific.

Mr Lamont: I will give you my story quickly and then you can decide.

Hon Mrs Caplan: The health maintenance organization is actually a way of organizing to provide services to its members. One of the services that they may provide could be found in a surgicentre or an urgicentre, but the concept of a health maintenance organization is not what this bill was about.

Mr Lamont: I will give you a quick story and then you can decide as



to whether I am on the right track or the wrong track.

The Chairman: Let's hear your story.

Mr Lamont: My mother lived down in Miami, Florida. One day I got a phone call and I said to her, "Have you been drinking?" She said, "No." I said, "You sound as if you have been."

Anyway, when I got off the phone I sat there for a while and thought, well, I had better get on an airplane, which I did, and I got down there. She was overdosing on either tranquillizers or sleeping pills.

I stayed down there about three months and she was getting in pretty bad condition and so forth. They have what we call the health maintenance organizations down there. They go around in a little panel truck or car or whatever you want to call it and pick up maybe 10 people throughout the city and then take them. There might be two or three or four of them arrive at the same time.

In the seniors' paper here, it says:

"Editorial note: Critics charge that the fee-for-service system encourages an assembly line type of health care in which doctors prescribe drugs more readily. Statistics show that about 75 per cent of all patient visits end in a prescription."

That is 100 per cent correct. That is the way they operate.

I will put it to you this way. If I were in charge of a medical centre and it was setting up something like this, and we will say the provincial government was going to pay \$5,000 or \$2,000 per patient per year, I would automatically say in my mind, "Okay, fine; 75 per cent of that is going to go into my pocket and 25 per cent is going to go to the patient."

As I said, they go around with the cars and so forth and pick up the patients. You get there. They herd them through like cattle. You do not see the same doctor when you go back again, because most of the doctors are fed up. They are not getting paid enough. They get out of there, so the next time you go you do not get the same doctor, the same nurse or even the same staff. I did not like this whole setup when I was down there. I still do not like it.

I will tell you what happened to my mother. I got a call from my nephew and he said, "Your mother is in a nursing home." When I had been down there previously, she had been told she would probably have to have a heart pacer. We said no. A little bit later at home, I said to her, "If you think a heart pacer would make your life more livable and so forth, maybe go for it."

I went home after three months. I have business of my own to take care of and so forth, but I took care of her for three months. As I said, when I was at home I got a call, and unknown to me, she had gone for the pacemaker. She suffered two strokes, one down one side which paralyzed the one side and she lost her speech.

Just at that moment, the HMO, the International Medical Center, went bankrupt down in Miami. My mother was in hospital and the hospital told my nephew or my niece that they had 24 hours to get her out of there. So they had to roar around and they got her into a nursing home.

To make a long story short, they have the system down there where you can sign a piece of paper and take all the necessary emergency care away from her and let her die, which I did. I think we should have that up here, which really has nothing to do with what we are talking about, but I thought I would throw it in anyhow. It is very easy to do. You just sign the paper and that is it.

Anyhow, she died, and when I saw in the newspaper that they were thinking of setting up medical centres and so forth, I thought perhaps this may have something to do with what I have gone through.

1440

I have the hospital bill here, which was sent to me, of \$800 and something. It was going into the bankruptcy thing and everything else like that and I did not know what exactly was going on. Later on I heard that Humana was taking over the medical centre.

Anyhow, the International Medical Center was in an older building and everybody was notified about moving into this brand new setup. It says here that the facility would be open on 8 December 1986. My mother died in June 1987, a very short time later. How come they did not know they were going bankrupt back in December 1986, even before they moved into the new building? I cannot figure that out at all. What I did find out was that somebody at the top there was helping himself to the money, at least that is my understanding—the big chief himself, whoever was in charge.

I do not want to see anybody in the province of Ontario get stuck the way I got stuck. It got paid; yes, I did not have to pay it, but it took two years to solve this whole mess and get it straightened around. At one place there—I got enough bills from them—they were talking about \$2; there was maybe \$35, I had sent a cheque and there was some little thing and so forth, and they sent it back. Rather than sending a \$36 cheque, we sent a \$34 cheque, \$2 down, and they kept billing me for the \$2. I said, "Hey, come on, knock it off. I have enough bills up here to paste the wall of a house or the apartment. Not only that, you have the \$2 down there."

As I said, the point is that I do not want anybody in the province of Ontario to get stuck with anything like this at all. It is not fair.

There is nothing wrong with the hospital system we have. All I know is Toronto's. I have had good service from just about every hospital in this city. I have heard all the yelling and screaming about the nurses and so forth. I agree with them. I think that is where your money should be going, not to these places. Give the nurses some good money and so forth and boy, you are going to get service.

There are a few doctors that—pardon the expression—may need their butts booted out, because they are not capable. I have three stories I could tell you on that which I am not going to bother to tell you.

Give the hospitals a little bit more money and I think we will have a good system. Pardon the expression again, but let's not screw it up. We have something good going here; let's leave it that way.

The Chairman: Thank you for your presentation. Perhaps we could start with the minister giving you a brief comment in reaction to your presentation and then see if there are any questions from members of the committee.

Hon Mrs Caplan: If I could, just very briefly, I have heard many of the horror stories from our neighbours to the south. I recently have had visits from senior US officials coming to look at our system, as they have their debate over changes in their health care system, to see what advice we can give them.

As you know, the principles of our medicare system, which is just about 20 years old, are accessibility, universality, comprehensiveness, portability and public administration.

The purpose of this bill is to acknowledge new technologies that are going to allow procedures presently being done on an inpatient basis to be performed in an outpatient and ambulatory alternative setting and to make sure, as we plan them in an orderly way to have the implementation of those new procedures in a community-based setting, that we have the kind of quality assurance, funding mechanism and involvement of the communities, through the district health councils, to set priorities and to determine what services are appropriate in the community in which they happen to be in this province.

There is no intention to import, through free trade or otherwise, the American style of market-driven medicine into this province. In fact, this bill has a clause in it which says that preference will be given to nonprofit Canadian proposals and that no international agreement will have an impact on the provision of our medicare system. Now we have had assurances that the free trade agreement, in fact, will not impact on the medicare system as we know it as a universal program. I just wanted to give you that assurance.

Mr Lamont: I was not particularly concerned about American or Canadian as far as that is concerned. What I am saying is that I do not want to see a medical system set up in this province that is similar to what they have in the States. It is as simple as that. They are no good down there.

Hon Mrs Caplan: That is correct. I have heard the horror stories; there is no intention. This bill is to simply allow us to plan, to fund and to have quality assurance, where procedures are presently provided in a hospital setting, which new technology is allowing through the change of medical practice to be provided in community-based settings and ambulatory and outpatient settings, for us to be able to respond by making sure we have a quality-assured environment and appropriate planning. I do not want you to worry about that aspect.

Mr Lamont: Just to bring to your notice, I am probably the person who started the getting rid of the OHIP premiums.

Hon Mrs Caplan: Congratulations.

Mr Lamont: I wrote to Dennis Timbrell 11 years ago about that and told him to put it through the income tax system.

Hon Mrs Caplan: I think we are all proud of the system that collectively—

Interjections.

Mr Lamont: Another thing you could do which I would like to see, which has nothing to do with what we are talking about: I brought it to Cindy Nicholas. Why cannot we get rid of the Hydro lines on the throughways? Bury them, put them down at the waterfront, put them up north, but get rid of them.



Look at that property that is there for housing.

The Chairman: Mr Lamont, you are getting into other topics. I want to see if there are--

Mr Lamont: It was a good idea, that is all.

The Chairman: Mr Lamont, would you just hang on? Would you just take your seat for a minute? I want to see if there are any questions from the committee members. There are none. Thank you very much for coming.

Our next presentation is from Dialysis Management Clinics. Representing that organization we have Igal Holtzer.

Mr Holtzer: A minor correction: Carol Holtzer will do the presentation.

The Chairman: Would you introduce the people with you, Mrs Holtzer?

DIALYSIS MANAGEMENT CLINICS INC

Mrs Holtzer: This is Franca Tantalo and Igal Holtzer, and I am Carol Holtzer.

Thank you for allowing Dialysis Management Clinics, which I will refer to as DMC, to make this submission. We support Bill 147, but we also share some of the concerns that have been well addressed over the past few days. As I said, my name is Carol Holtzer. I am a registered nurse and a director of DMC. I have 15 years' experience in nephrology. I am currently employed as a clinical instructor for haemodialysis and have worked in this capacity since 1982. My duties include active involvement in setting standards, monitoring and evaluation of quality assurance programs specific to dialysis. I have authored and co-authored abstracts and papers for presentation at international conferences. I have also been actively involved in research being carried out within the area of nephrology.

As I said, my partners are Igal Holtzer and Franca Tantalo. They are both directors of DMC. Franca is also a registered nurse. Igal is the business director of DMC; he is a graduate of the University of Western Ontario, with a degree in computer science. His background includes engineering and business. Presently he is the Canadian sales manager for a software firm. Igal has actively researched dialysis facilities by seeing and speaking to other centres throughout the world.

1450

Franca has 21 years' experience in nephrology. She has been employed as a teacher, a head nurse for home dialysis, as well as head nurse and clinical co-ordinator in various dialysis units in Ontario. Franca set up the first dialysis units in Sudbury. This experience involved setting policy and procedure manuals as well as hiring and training of all the staff. Franca has also presented and co-authored abstracts for presentation at conferences. All of the partners are Canadians.

Our objective today is to outline our activities during the past eight years and our views on Bill 147. Our agenda is as follows: first, an overview of the Dialysis Management Clinics; second, our views of Bill 147 and recommendations; our conclusions, and then it is open for discussion.

Dialysis Management Clinics opened its doors in 1982 to provide a service for kidney patients travelling to Toronto from around the world. This need arose due to the shortage of beds and nurses in the haemodialysis units in the Toronto hospitals. Initially, our opening met with resistance from various members of the nephrology community. This resistance has disappeared as our high standards of quality care became known. Patients are now being referred to DMC by all existing Ontario units, from other units across Canada and from around the world.

The Kidney Foundation of Canada has been our advocate and has actively lobbied in support and recognition of our services. Correspondence between the kidney foundation and the ministry is available.

Dialysis Management Clinics is a for-profit organization. However, our operation is more cost-effective than the existing nonprofit facilities. Our medical director is Dr Paul Tam, a nephrologist.

DMC's mission, in the first five years of operation, was to provide travelling dialysis patients with haemodialysis facilities. Due to numerous requests from Canadians, our mission grew to include the following: (1) to provide haemodialysis facilities for Canadian patients, not only for out-of-country patients; and (2) to assist the government in reducing the ever increasing cost of health care.

Our patients have included visitors from numerous countries, remaining for one treatment and up to six months awaiting transplantation. The majority of the patients are US residents. Canadians are a minority, yet pressure to dialyze this group of individuals has been high. For example, we have provided emergency dialyses during a hospital crisis. No fee was reimbursed for this assistance as no mechanism for payment is established for private-facility treatments. We have also been reimbursed for dialysis treatment by the Department of Indian and Northern Affairs, the Department of National Defence, and private corporations when provincial governments will not cover the cost.

Until such time as we are a licensed facility, some provinces will not recognize interprovincial reciprocal billing from us. Ironically, these same patients, as well as Ontario residents, may cross the border and be reimbursed for dialysis in private, independent health care facilities.

Bill 147 is a positive move towards providing universal health care, accessible to all Canadians. It will not only allow care givers but also care receivers to co-operate in health care planning. It has been proven by studies, as outlined in your brief, that free-standing clinics in operation in other countries can provide quality care in a cost-effective manner.

In our opinion, Bill 147 will reconfirm the success of these independent facilities, with the amendments proposed by others as well as ourselves. We would like to elaborate on only a few of the sections of the act. As we have stated before, many areas, for example, confidentiality, have been well addressed.

Our major concern is sections 6 and 10 of the act. Sections 6 and 10 refer to issuing and transferability of a licence. Our question is: Are you licensing a person or a facility?

We are not in the legal profession, but throughout the act reference is made to a licensed person versus a licensed facility. This could be misleading especially with respect to transferability. We believe a facility should be

licensed and that the facility continue to operate under the guidance of the ministry. We have worked many years to build up our practice. If we, as owners or operators, wish to terminate our duties, we should have the same freedom as the ministry has to suspend, revoke or refuse the licence. Physicians may sell or transfer, for a fee, all or part of their practice without any government interference. Why should our practice be any different?

Our facility deals with chronic repeated treatments. If a licence is not transferable, what then happens to these individuals when we no longer wish to continue our practice or the government refuses to renew our licence?

We are therefore recommending a change in the act to read that the facility is licensed and that a licence is transferable. The new operator should be reviewed by the director to ensure that the standards set for that facility are being maintained.

Section 14 states, "A licence shall not be used as security...." If a facility requires further funds for expansion of services or other needs as they arise, an application for a loan at a financial institution will be initiated. Most banks will request projected revenues. These revenues will be reported by us based on the facility's licence and government funding for services. We believe therefore that the facility's licence is the security used as collateral.

Sections 16, 17, 18 and 19 refer to taking control, revoking, suspending or refusing to renew a licence. The review of licences should follow hospital accreditation procedures. Guidelines are already established for the selection of assessors and inspectors as well as their role in the process with respect to their area of expertise. Recommendations are made upon this process. Each facility is given a verbal and a written report as to the findings. The length of renewal of a licence is dependent upon this report. Facilities are then expected to correct any areas commented on within this period.

It is stated in the handout, the Independent Health Facilities Act Fact Sheet, "The ministry's most recent estimate is that 20 facilities may be eligible for licensing under grandfathering." We hope that grandfathering of existing clinics is applied equally to all.

We propose, first, that all clinics operating as of 2 June 1988 are grandfathered; if this in fact is not the case, we also propose that an appeal procedure be set up for those facilities which are refused grandfathering.

In summary, we believe Bill 147 will benefit, first, the patients or the care receivers by: (1) providing alternative facilities at more convenient locations; (2) increasing opportunities for travel within Canada; and (3) encouraging independence and rehabilitation.

We also feel that it will benefit the ministry by: (1) reducing operating costs; (2) minimizing the need for new money or capital budget—our facility at present can manage 12 chronic haemodialysis patients at no extra capital cost to the ministry; (3) reducing the cost of transporting patients; (4) establishing of actual costs for services provided; (5) projecting accurate health care costs for future planning. There is no true cost of dialysis services for total care in Ontario. Each hospital works under a global budget. At present there is no set per dialysis cost. Our cost per dialysis is the most accurate as we have had to keep accurate records for accounting purposes.



In conclusion, DMC supports Bill 147 provided that amendments are made based on our recommendations presented prior to the act becoming law; and (2) DMC would like to submit a proposal for licensing to work co-operatively with the ministry to help it meet its objectives.

The Chairman: Thank you for your presentation. We will now see if there are some questions. We will start with Mr Carrothers.

Mr Carrothers: I very much appreciate you coming in. I found your presentation very interesting. It seems there may be a bit of an anomaly surrounding the type of medical service you provide, and perhaps this legislation is the framework to solve that. I wanted to specifically ask some questions on your comments on page 6, on the transferability of a licence.

I am not quite sure I understand why you feel you need to have the licence transferred. You have drawn an analogy to physicians and the transfer of their practice. A physician does not sell his licence to practise; it is not transferable, just as this will not be. Presumably what he or she is selling are physical things such as an office lease, equipment those types of things; a patient list, perhaps.

1500

I could see the same thing could exist in the case of a clinic like yours. If you were to stop your activity, and I am assuming the reason you feel you need to transfer is recoup some of the expense you have invested, it seems you are actually in the same position a physician is in. I am wondering why the licence itself would have to be transferred in order to put you in the position you feel you need to be in.

Ms Tantalo: I will answer that. We may have misunderstood the terminology "transferability" to mean that if DMC had a licence, it is the clinic that has a licence, not myself or Carol or Igal. I am a licensed registered nurse. I am licensed to practise in Ontario. If we wished to depart our partnership, would I take the licence with me, or does the licence remain with the clinic? I think it was just a misunderstanding of the word transferability.

Mr Carrothers: Maybe the ministry could clarify. I assume it would depend upon how that licence was issued, whether it was issued to a group or an individual.

Ms Gotlieb: We would be licensing the corporation; we would not be licensing the facility. We would be licensing the person, which could include a corporation that operates the facility.

Mr Carrothers: Or the group, I assume, that might operate it.

Ms Gotlieb: Or the group.

Mr Carrothers: It may be, depending on the circumstances, that she might take it with her.

Ms Gotlieb: Yes.

Ms Tantalo: If we decided to venture into other areas, we could not sell our licence? We would have to sell the business or—

Mr Carrothers: That is right. I guess that is the question I asked, because it seems to me you are in the same position, that even you as a—Well, a nurse does not, but if you were operating, your licence to be a nurse is not a transferable asset.

Ms Tantalo: No.

Mr Carrothers: And a doctor's licence is not transferable, as this is not.

Ms Tantalo: No, but we are licensed by our professions. What we are asking is: Is the facility licensed, and why can it not have owners other than ourselves if the function of the facility is what is licensed? That was my understanding.

Mr Carrothers: Okay. When I hear you say that, what I am thinking in my mind—I may be misinterpreting, but we have had some speak to us about the fact that they have worked the business up and that they have made an investment and there is goodwill and so on attached to that and that they would like to recoup that if they stopped doing this activity. The point I was making was that that is the same problem a doctor faces, and they can do that without transferring the licence. I am suggesting that the transferability of the licence is not necessary to do that, and asking why you feel it is.

The Chairman: Any further comments?

Mr Carrothers: I have one other, very brief, if I could. It was your comments on section 14 about security. Maybe in a way it is an offshoot of the same thing. You are talking about a bank taking security, and the licence is a way of financing. Again, a physician cannot pledge his licence to the bank, but they get financing from a bank or whatever, assuming they need it, based on the fact that they can operate for a period of time.

It seems to me that with these licences being issued for five years, which by and large seems to relate to the time over which any facility, the machines and so on, their active lifespan—You have that five-year window. If there needs to be some sort of financing, it could happen without the licence itself having to be pledged, because of course one of the ways to transfer a licence without permission is to pledge it as security in default on the loan. It is a well-known trick. I think the reason you are not allowed to secure it is to prevent that kind of back-door transfer.

I may be misinterpreting, so if you have any further comments I would like them, but it seems again to me that for any kind of financing you might need—and it may not be that great, because I think the idea of this act is to provide the financing of those capital facilities; you might not have to go outside that financing to pay for the equipment anyway—you could have that five-year licence, which would be, I am sure, the kind of time frame over which any bank or anything else would want you to pay back that financing anyway, because that is the active life of the equipment you are buying. That is how I would see it. Again, I may be misinterpreting and I wondered if you had any comment.

Mrs Holtzer: Again, it is more in terminology and what these things mean to us as an existing facility that is operating and what it will mean to us long term.

Mr Reville: On that last point, as I read the legislation, there is

a specific intention not to create economic value in the licence itself. I think that is the intention of the government in that regard.

I have had a chance to meet the Holtzers in connection with the Kidney Foundation of Canada which was trying to get the government to change its policy so that it would pay for dialysis for a person travelling here from Ottawa, for instance, because of course the government will pay if you go to Miami but not to Toronto, which seems like a curious idea to us. I take it dialysis is not an insured service. Is it an insured service?

Dr MacMillan: It is an insured service other than by regulation of the Health Insurance Act, which does not make it an insured service in a private facility in Canada.

Mr Holtzer: In Ontario. Of course, if they go to a private clinic in the US—

Dr MacMillan: I said in Canada.

Mr Reville: You said it right too, Doctor.

Dr MacMillan: Thanks.

Mr Reville: When the government is right every now and again it is great news.

So this is an anomalous situation, I should think, where the health management clinic does provide a service that under some circumstances would be an insured service, but it is not an insured service because it is not in a hospital in Canada.

Dr MacMillan: Yes, but there is something else that is very important. In the drafting of that regulation, as I understand it, formerly there has never been a way of assuring the same quality of care in a community setting. It is fair—

Mr Reville: You could do it under this legislation.

Dr MacMillan: It is fair to conclude that with this legislation it would be redundant and that it would make it, certainly in Ontario, not worth while to differentiate between getting it in the community and in a hospital.

Mr Reville: So we might be on the threshold of a new day for Dialysis Management Clinics, because you could look at their quality under this law.

Hon Mrs Caplan: At this time, we are actively reviewing that policy, as we have in another area where I think there are some analogies. As I mentioned before, the policy has been changed on the requirement for in-hospital birthing centres only. The fact that under this act we can have a quality-assured environment in an independent health facility is allowing us to look at a number of existing policies. The policy for dialysis services is but one of a few that we are reviewing.

Mr Reville: We will be able to talk about birthing centres, I think, on the 21st.



Hon Mrs Caplan: But you should know that we are reviewing the policy as it relates to dialysis. This bill gives us for the first time a legislative framework to have a quality-assured environment outside of a hospital setting, and the ability to fund that as well as plan for the orderly development of appropriate community-based facilities.

Mr Reville: How would you deal with a facility such as this, which actually charges a facility fee to some of its people but would not to others if in fact it were licensed? I would go in and get dialysis and I would not pay, but my brother from Chicago would go in and would have to pay.

Hon Mrs Caplan: In fact, that is no different than what exists today.

Mr Reville: That would be weird.

Hon Mrs Caplan: No. In fact, today Americans frequently come to Ontario for services in our hospitals.

Mr Reville: Some people even think they get to the top of the list because they pay.

Hon Mrs Caplan: They pay for services.

Mr Reville: I am teasing you.

Hon Mrs Caplan: The Ontario taxpayer does not pay for anyone other than Canadians as part of the Canada Health Act. Anyone coming to Ontario is responsible either to pay the bill or the insurance may cover it to some degree.

Mr Jackson: In the absence of an interprovincial agreement.

Hon Mrs Caplan: We are part of an interprovincial and international network, but unless arrangements have been made, and as you know portability among provinces and interprovincial agreements are in place, but for—

Mr Reville: Except with Quebec in some cases.

Hon Mrs Caplan: Even there, we are working those through as well.

Mr Jackson: We are almost fully socialized and then we will have no trouble with Quebec.

Hon Mrs Caplan: You do not support medicare? Is that what you are telling me?

Mr Jackson: We are not fully socialized yet is what I said, Minister, but we are getting there, and then you will be able to have an agreement with Quebec, as you well know.

Mr Reville: Like me, Mr Jackson is pushing for more socialization in this country.

Hon Mrs Caplan: Just to stay to the point, the reality is that Americans come here on a regular basis and pay for the services. I think we all agree that is appropriate. Our system is for Canadians.

Mr Reville: Thank you. That was really illuminating.

1510

Mr Jackson: I would like to get back to this business of selling a licence, or who holds a licence and conveying a licence. I understand the concept and I understand the concept in which you are conveying it, from the process of building up a business and its having value, as well as in a partnership where for whatever personal reasons one or two of the partners feel they must dissolve that partnership.

Therefore, it gets complicated because the value stays with the facility in operation and cannot in any way, shape or form be detached. It is sort of like a gun to your head that you must stay there the five years if you are one of the principals. Hopefully, we can pursue that with some more creative ideas, but so far we have heard only the problem and not the solution.

I guess my first question might be back to the minister on your behalf based on the question you have raised. That is, it is my understanding that a retiring doctor can sell his patients list, his business. He is not selling his licence, but he is selling his practice. He can sell that to a junior. He can sell the equipment. He can sell his patients list. He sends out a nice letter saying, "I have conveyed my practice to this wonderful young man"—or woman—"and I recommend you come and see him"—or her—"right away."

In that sense, when Mr Carrothers raised the question that you cannot really sell a licence, there is something that is done along the lines that Dialysis Management Clinics has conveyed to us. Knowing that this is occurring in private practices all across this province, to what extent would there be any effort to limit an application from a group like DMC as an independent facility under your legislation and not recognize any costing that might be associated with a purchase or an acquisition price?

You know the hypothetical example. DMC has operated for 10 years and they want to get out of the business. They sell it and say, "Okay, you are on your own to face the government, but we are going to sell our interest for \$50,000." Now they have to build five-year payments for the \$50,000 into their proposal and that hits your desk.

I guess one of the fears is that you can be silent in legislation, but if your regulations specifically prohibit recognition of that \$50,000, which would be modest, but they still would not recognize that cost in any way, shape or form, then there would be a serious problem. That would have repercussions for all people in the medical profession who operate in such a fashion.

Hon Mrs Caplan: I suggest what we are looking at in this type of facility, by and large, is very different from what you have in a physician's family practice where he develops the patients who come to him on an ongoing basis over the course of a long time. While not all, most of the procedures that are going to be carried out in an independent health facility will be the kind that are service-centred, procedure specific, where a person goes for cataract removal. They may go once, they may go twice, but it is not an ongoing relationship; for example, the birthing centres we were talking about.

Again, the urgicentre or surgicentre for minor surgery that can take place safely in an outpatient and ambulatory clinic is a very different environment from what you would have in an established family practice. So I

am not sure that the analogy of the ongoing relationship is the same in the establishment of—

Mr Jackson: I think dialysis is a very good example because dialysis lends itself to a continuous program of service and medical attention, whereas cataracts, albeit recurring, are not recurring in the same process as in all the other renal-related medical conditions.

Hon Mrs Caplan: I used the phrase "by and large." Certainly, there will always be exceptions.

Mr Jackson: Maybe we can go back to my question. It just has to do with this concept of the structuring of an expenditure that shows within it.

Hon Mrs Caplan: I think the policy is very clear. The intent of the legislation is that the licence itself not have any intrinsic value. That is the reason for the licensing of the individual or the corporate entity, which will then be held accountable. The term of five years will allow for the full term and depreciation so there is no specific value of that licence. That is the intent of the legislation. I think that while we will have an opportunity to discuss that, it is very clear in the legislation that—

Mr Jackson: For the benefit of the committee, there are some very specific ways of dealing with that. There are about four different ways of conveying—

The Chairman: We are getting into what we might debate later as a committee.

Hon Mrs Caplan: Clause-by--clause.

Mr Reville: He is winning, so you better cut him off.

Mr Jackson: Unless we are holding up another deputant—

The Chairman: No, we are not, but I just do not want this to be seen as a precedent in terms of other delegations when we do get into tight timing. I am being a little more flexible here but you are taking the time of the delegation to question the minister rather than the delegation.

Mr Jackson: I do not think they are having any difficulty with my line of questioning.

The Chairman: Perhaps we could ask the delegation if it has any comments on the exchange that we have heard, because it is your time now.

Mr Holtzer: We feel very strongly about this point. We would like to continue that.

The Chairman: Fine. I just wanted to check that.

Mr Jackson: I know it is going to continue—

Mr Fleet: Before we go off on another strain, if I might—

The Chairman: You are on the list if you could just wait.



Mr Fleet: It is pertinent. I have the feeling he is about to go off on a different—

Mr Jackson: No, I am close to finishing my comments. This issue has been bothering me. I know we are going to get hit with it continually and I have been giving it some thought over the course of the weekend. That is why I would like to get a better sense of where we might go with the regulations on this matter, because there are several ways of selling or conveying businesses and there are several ways of calling goodwill something other than what it is. You can include it in the price of the furniture. You can sell an after-the-fact professional management fee.

Mr Reville Key money.

Mr Jackson: No, it is not key money. You behave.

You can take a very specific formula approach that is used by a major franchise operation in order to put a very specific and narrow range on what can be transferred and what value can be placed on it. There is a world of difference between the four different methods of conveying the licensed facility and all of its value. I just wish to point out that, hopefully, we will get legal counsel to address that in more specific terms, before the legislation is passed, so we know in what context it will be placed in regulations.

I get a sense from the minister's response that there will attempt to be a rather narrow approach by virtue of the fact that the goals are to be service-driven and not-for-profit. That is a stated goal of the government and I understand that. I am not about to debate it here ideologically because Mr Reville would demand equal time. I just want to put that on the record. That is asking legal counsel to come up with some of those responses, not the minister or others, because it is a highly legal question I am asking.

Finally, if I could ask only this one point, Mr Reville raised the issue of DMC operating as a clinic with a facility fee currently for foreigners, if we can just state that as a general statement. As I understand it, we have come to the point where we can foresee under your legislation that DMC could be grandfathered, be accepted as a clinic and could continue to charge a facility fee to foreigners. We understand that. Your legislation enables that, or is there some—

Hon Mrs Caplan: I am going to ask Bob MacMillan to respond because there is a technicality on that.

Mr Jackson: That is what I would like to get a better understanding of.

Dr MacMillan: The definition of "insured service" is a service that is prescribed by the regulations—in other words, in our schedule of benefits—and payable to a legitimate registrant. In other words, an insured service, by definition, goes to someone who has OHIP in Ontario. If they do not have OHIP and if they are not from Ontario, they are eligible for what you call insured services because they are not technically receiving insured services by our legal definition.

Mr Jackson: Okay. So they can continue to treat foreigners. Can they treat foreigners to a level of service that is greater than the level of service that is being delivered to Ontario residents, either in terms of

procedure or application? Will there be any restrictions in terms of the regulations? I can give you all sorts of examples.

1520

Hon Mrs Caplan: I guess you are getting into an area that likely tends to confuse, because you are now talking about services we would consider noninsured services provided to residents who are non-Canadian. The issue is, for an independent health facility, the services and the quality-assured environment, the services that were being provided, all of that would be discussed through the proposal call.

The question of how Americans access our systems is really unrelated to the provisions of this bill, which deal with how Canadians and Ontarians will have access to services in these facilities.

Mr Jackson: But the point of my question is to get an understanding of if there will be any restrictions in terms of the volume or percentage of business that is attributed to nonresidents. I think that is a valid question to be asking because people could set up a clinic that gets in the front door to control a portion of the Ontario market, but then can boost its volume through flooding it with foreign patients. That is a legitimate concern, as you know, with cash customers in a sense. people paying a facility.

Hon Mrs Caplan: Those are the kinds of questions that I think the process of licensing could take into discussion and consideration at least. Certainly, it is very hypothetical today. The goal of this legislation is to provide services to Ontarians in a quality-assured, orderly, planned manner with an appropriate funding mechanism.

Mr Jackson: So there is no regulation being considered that would restrict in any way access to services greater than or above the level of service for Ontario residents?

Hon Mrs Caplan: I guess you would have to be specific. Certainly the regulations I am empowered to regulate under the act would allow us to respond appropriately. This bill by its very nature is very flexible, so as in any piece of legislation the fine-tuning by regulation allows us to respond appropriately to situations that occur. It is very difficult in advance to try to hypothesize on what may or may not occur after the fact.

Mr Jackson: It is not a hypothesis. I will leave that as my second question for legal counsel to identify if the legislation is silent on the issue of whether it can restrict in any way the capacity of a facility to provide services greater than the level of services provided under the prescribed services under the Ontario health insurance plan.

I do not wish to get into the dozen or so cases. We have a lithotripter clinic operating in Hamilton. Americans are being airlifted in here to use that. If that becomes an Ontario-based facility and we are still airlifting Americans in here, then I would want to know the extent to which the mixture of American versus Ontario residents is preserved, and I would want to ensure that the reliance on the levels of service in that one example—I could give you several others. It is not hypothetical. It is a valid consideration within the context of this legislation.

I would like to thank the deputants for bringing forward their presentations. I think it has given us a clearer look at one of the current

clinics operating and one of the problems this legislation will present to you." I thank the chairman for allowing me so much time.

Mrs Cunningham: I just have a couple of questions. After this discussion, I think my assumption is that there is not going to be a change in sections 6 and 10. Given that, I am going to ask a couple of questions.

You are aware that a new or expanded program under this new legislation will have to have the approval of the district health council. I am assuming that yours is an extremely integrated program in that sense, because you are already working with hospitals that have defined a need for your service and you are not thinking you are going to have any difficulty getting that approval.

Mrs Holtzer: I would not think so. We have certainly talked with the district health council before and all of the appropriate people are aware of our existence and what we do in our qualifications. I do not really see it as being a problem. We understand a process that must go through.

Mrs Cunningham: Others, I think, may see that as being a real problem because they have not been working with health councils, are not established and they have to go on a priority basis.

My next question: From then on, it seems to me you are aware that the licence separate from that will be issued centrally by the director, not the health council. That is not the mandate of the health council. Would that be your next step, then, to get the licence?

Mr Holtzer: We are not sure about that.

Mrs Cunningham: You are not sure. The reason I am asking the question is that you said you support the legislation, but I think you cannot support it without some changes to this issuing of the licence.

Mr Holtzer: That is what we are saying.

Mrs Cunningham: I am agreeing with you, but I am not sure where we go from here either, because your district health council can say yes and a director may say no. If the minister steps in and says no, you have no choice, but you can appeal the decision of the director. So we are looking at a bit of bureaucracy here, are we not?

Mr Holtzer: Right.

Mrs Cunningham: Assuming you get the licence to operate—obviously, you have the first thing—if you do not get this issuance or the transferability, would you still be willing to operate under the circumstances that you are operating under?

Mrs Holtzer: We do not really know. I think that is something we will have to look at as time goes on; we are just looking at it ourselves now. We have been around for a long time. They have put a lot of years of work into it for not an awful lot of return. I think it is an issue we have to look at very carefully.

As you know, all three of us work full-time somewhere else and this has been a very important part of our lives for a lot of years. We definitely have to look at it very carefully before we decide what we would like to do with



it, and we do not know at this point. This is something we need to know from you.

Mrs Cunningham: Is the time frame the problem with this aspect of the bill, the five years, or is it a bigger problem that you cannot plan that far ahead, you wish you had longer to plan ahead or you want more time, or is the problem the fact that you would have understood that as a private business, in the sense that you have described yourselves, you may have passed it on to someone else for a fee? Or are they equal problems? What is the real problem?

Ms Tantalo: My problem is—and I think my partners share this—where are we at five years from licensing? We can be closed down today or given another five years. It is just the uncertainty as to whether your clinic can continue servicing the patients. If the ministry or the director decides that we no longer need this service, how do they decide?

What if we have 50 chronic haemodialysis patients on dialysis at our facility and five years from today our licence is revoked? What does the ministry plan to do with those 50 patients? It is just the fear of the unknown. I am assuming that if our service is quality assurance, we can prove that we provide the service. But we should have no doubt that our licence would be renewed. It is that uncertainty that it can be revoked or suspended without our input, other than through the appeal session. It is just the uncertainty.

Mrs Cunningham: How long have you been operating now?

Ms Tantalo: Eight years.

Mrs Cunningham: And you can go on the way you are now and the people who get your services now are people who are prepared to pay for them themselves. Is that correct?

Ms Tantalo: It is also very seasonal. We are constantly called by Ontarians saying, "Can't you do something about my mother who needs to come to visit Toronto?" We are basically pushing for patient care right now, or accessibility of dialysis in Ontario. Our travelling patients are seasonal; there are months where we will have no dialysis taking place at our facility, but if we had licensing and were able to do Canadians, then our business would no longer be seasonal.

So we are basically fighting on behalf of the patient, not on whether our business is to continue or not. Yes, we need a patient load to maintain the service. How many people travel when you think about these patients who are on chronic dialysis?

Mrs Cunningham: I am appreciative. I was curious as to how you would answer that question.

Mr Carrothers: You raised the point about the terminal licence and the uncertainty of renewal and I was intrigued by that. Most licences are term specific; they always have some. As an example, a television station gets a five-year licence and technically does not have to have a renewal. That does not seem to present a problem to them. I am wondering why you would feel that is such a piece of uncertainty.

Interjection.

Mr Carrothers: That is the point I am making, Mr Jackson, and she may have made it herself. Just because it has a term, technically—if the service is needed and so on, obviously those licences go on and on and on.

Ms Tantalo: I would put my confidence in the ministry that the licence would not be revoked at the expense of the patient who is being served by the facility.

1530

Mr Carrothers: That is the point I was making, that licences usually have a term and I did not know why that would, in and of itself, be another cause of uncertainty.

Ms Tantalo: We have never dealt with that uncertainty before.

Hon Mrs Caplan: I guess when you talk about the uncertainty, in these rapidly advancing technological times the question would be, what if there were some new advance in the treatment of kidney disease and in fact dialysis were old, outdated and no longer necessary and there were something new. That is the sort of "what if" the five-year licence contemplates. I certainly understand the point you make. That is why the needs assessment is required at the time of determining the renewal of the licence.

The Chairman: I am not cutting you off, Mr Fleet, but I do have an item I have to ask the committee about now. Do you have time to stay a few more minutes to take one more question? I just wanted to interrupt your time for a moment.

One of the organizational items I wanted to raise with the committee after our delegations had concluded today was the request that was made to hear Debi Mauro or to have an opportunity to ask her questions. She is not available. She is out of the province next Tuesday when we had hoped to bring her in here.

Mr Reville: It may be an interesting country. Maybe we could go there.

Hon Mrs Caplan: Overlea.

Mr Reville: Where? Overlea Boulevard?

Hon Mrs Caplan: No, today. Soon she will be in Saskatoon.

Mr Reville: Sorry, no deal.

The Chairman: The reason I am interrupting now is that she has indicated she can be here in half an hour if we are prepared to take her at four o'clock and if the committee wishes to stay later today. Is that something the committee wants to do? Or we can try to fit her in later this week, but it is tighter the rest of the week.

Mr Reville: Yes, it is. Maybe she had better come on down.

The Chairman: Is that okay?

Dr MacMillan: You could save some time by asking some of the questions of Marsha Barnes, who has been the main one behind the organizing.

The Chairman: So we could start before she arrives.

Hon Mrs Caplan: That is correct; as soon as we are ready, while Debi is on her way.

The Chairman: We have two or three organizational items. Is that agreeable to the committee? Okay. Carry on with your question, Mr Fleet.

Mr Fleet: This is really supplementary to points Mr Jackson was trying to bring out. I just wanted to get a clarification. In my understanding, the value of a licence would not be something you could attribute to goodwill, but the legislation itself did not prohibit or contemplate the prohibition of the sale of goodwill. Is it correct that goodwill could be other aspects of the existence of the business?

Dr MacMillan: The value is in that the doctor taking over, as Mr Jackson has said, expects that probably 80 per cent of the patients are going to continue to come to him. There is quite a value in that because he moves right into an established practice. The difference could be that if they suddenly lost a licence in a clinic and there were any kind of gap or anything, then the patients would immediately find other community resources. That is the way I see it.

Mr Fleet: Then I think what I said was right. It does allow for sale of an interest, apart from the licence, which would include goodwill. Goodwill could attribute to a lease, I assume.

Hon Mrs Caplan: The intention in the funding structure, which is negotiated during the licensing process, is that the facility fee is to cover the overhead costs, the service component covers the staffing fees and that sort of thing and the licence itself has no inherent value. The assets would be part of the facility fee which would be depreciated over the course of the five years, and during the term of the licence, certainly the value of the assets would remain. There is no intention to have an intrinsic value for the licence itself.

The Chairman: Thank you for coming and sharing with the committee your perspective on this bill.

A couple of items have come up that I should bring to the attention of the committee. Should we proceed without Debi Mauro?

Hon Mrs Caplan: Yes, Marsha is here.

The Chairman: She has gone to call Debi.

Hon Mrs Caplan: Here she is.

The Chairman: Basically, the Ontario Psychological Association contacted the clerk. There may have been a slipup in terms of the fact that they claim they called the clerk's office after the advertising and nobody got back to them in terms of scheduling an appointment. The staff person who may have handled this is no longer in the clerk's office, so we are giving them the benefit of the doubt and we are going to be scheduling them at a 1:30 time, if that is okay with the committee. Normally, we start in the afternoon at two.

Mr Carrothers: Are we not sitting Tuesday week? Could that not be a time to fill?



The Chairman: It could be. However, remember we had wanted to finish all of the public presentations by the Monday night so that Alison could include them all in the summary she is going to give us on Tuesday morning. I was trying to fit it in this week rather than scheduling it Tuesday morning.

Mr Carrothers: I just wondered if, in terms of trying to shoehorn things in, there is a logical time. The miracles of word processing being such as they are, Alison could probably add that in fairly quickly.

Ms Drummond: That would simply mean I would not be able to get it to this committee in its full form by the Wednesday. It is really up to the committee whether you want it. I thought on Bill 211 there is a little bit of trouble with that, because a couple of quite important organizations presented on the day we went to the Clarke Institute of Psychiatry, so they were not in the summary at all.

The Chairman: Is there objection to meeting at 1:30 on Wednesday or Thursday of this week to accommodate the Ontario Psychological Association?

Mr Carrothers: I guess not.

The Chairman: Okay. The other point is that the clerk was contacted by Sidney Linden, the Information and Privacy Commissioner. He has noticed the publicity with respect to the whole issue of confidentiality and patient records and is prepared to appear before the committee to answer questions if we would like to have him. We could try to work him in some time during the week or, alternatively, we could bring him in on Tuesday morning, because he is not basically part of the public delegation; he is simply here to provide us with information.

Mr Philip: That would be this coming Tuesday?

The Chairman: No, a week Tuesday morning. We could work him in on the Tuesday morning.

Mr Philip: You would bring him in early, would you?

The Chairman: Yes, the first thing Tuesday morning, 10 o'clock.

Mr Philip: I guess I will read his presentation in Hansard. That is fine.

The Chairman: Is that okay? I thought the committee might be interested in that.

The final point is that, given the importance of these hearings, I have been asking the clerk to check whether or not room 151 might be available for at least some of our hearings so that people in our communities could follow the presentations. It appears that Thursday of this week and Monday of next week we can be scheduled to be in room 151 with television coverage of the committee, so if it is agreeable to the committee, we will be in there.

Mr Carrothers: Is the temperature any better in that room?

The Chairman: You have the bright lights to warm things up, but it is often not any better, no.

Mr Philip: As long as you are not pre-empting the standing committee on public accounts next week, I have no objections.

Mr Carrothers: That is playing favourites.

Mr Philip: Mr Dietsch and I are playing favourites.

The Chairman: You will check that with Mr Reville, will you?

Mr Philip: It is a nonpartisan decision.

The Chairman: Just a final point of information, and that is that tomorrow we may be visited by a class of observers, new government employees who are on an orientation seminar program with the Civil Service Commission and are interested in seeing how the legislative committee process works, so be on your best performance.

That concludes the organizational items. Why do we not take a five-minute or 10-minute recess? We will wait for our opposition critics to come back and then we will start, since they were the ones who requested this.

The committee recessed at 1540.

1557

The Chairman: The committee will come to order.

Mr Reville: If I may, I thought it would useful, certainly for me and perhaps for other members of the committee, to get at a brief overview of the district health council system in general and any specifics that relate to the needs assessment and proposal call generation aspects of Bill 147. That was my intention, partly just to disabuse myself of vast ignorance about district health councils and to see what I could learn about how district health council operations will be reflected under this bill. Whatever Marsha can share with us in that area would be helpful to me.

The Chairman: I would like to welcome Marsha Barnes to the committee. Would you introduce yourself and make some brief opening comments, then we will take questions.

#### MINISTRY OF HEALTH

Ms Barnes: I am Marsha Barnes. I am the manager of the alternate funding unit in the health insurance division and I have been charged with overseeing the administration and development of the Independent Health Facilities Act. I think perhaps Debi Mauro is the best person to talk about the district health council program and system in Ontario in general. I can tell you a bit about it.

I think there are now 27 district health councils in Ontario, voluntary planning bodies which are made up of consumers, providers and local government representatives. They usually have an executive body and then the council itself which has a maximum, I think, of 24 members. They have a small staff—I think the maximum staff, at Metropolitan Toronto District Health Council, is eight—to support their work.

What they will do is provide advice to the minister on local planning needs. They will do special studies, they review and rank proposals for hospital-based programs, for community health centres, for public health departments and also comment on the placement of nursing home beds.

What we have been doing is working with a representative group of district health council people, staff and members, and a joint group of the district health council staff and our unit staff to look at guidelines to assist them in doing these assessments for independent health facilities. We are contracting with the University of Toronto to assist us in that development. At this point, we have sent some guidelines out to the councils to comment on. We are going to be pilot-testing them in the communities and getting comments back before Action Centre, October 1989, in order to—

1600

Hon Mrs Caplan: Could you just describe what Action Centre is for a minute?

Ms Barnes: Action Centre is the annual conference of all district health councils for their members and staff, where they come to discuss issues of joint concern and to hear presentations etc.

The reason we have taken this process is that there was a feeling that councils needed to have some assistance in bolstering their skills for needs assessment. In addition, the act may require that councils appear before the Health Services Appeal Board to justify the process they use in assessing the needs.

Mr Reville: I do not know what that is, the Health Services Appeal Board.

Ms Gotlieb: The Health Services Appeal Board is a statutory body set up under the Health Insurance Act. It could also be set up under this bill to hear appeals of decisions made by the general manager under the Health Insurance Act.

Mr Reville: That is you?

Dr MacMillan: I think in this act it is appeal of the decisions of the director.

Mr Gotlieb: Under this bill, it is the director, who is Bob. Under the Health Insurance Act, it is the general manager, who I believe is—

Dr MacMillan: The assistant deputy minister.

Ms Hosek: Can you give me an example of the kind of questions the health services appeal people might have to answer?

Dr MacMillan: For instance: "How come she got a licence and I did not get a licence? I think the DHC was unfair, and I question the rationale it went through in making this judgement."

Mr Reville: Is that in addition, though, to the ability to appeal to cabinet? Is that an intermediate appeal level?

Ms Gotlieb: No, it is not an intermediate appeal. It is the main course of appeal where there is a decision made by the director; the director makes any kind of decision to do with issuing a licence or revoking a licence. There is one situation, where the minister will refuse to renew a licence; in that situation, you have a petition to cabinet. But in most cases the appeal will be to the decision of a director.



Mr Reville: That is in this legislation?

Hon Mrs Caplan: That is correct.

Mr Reville: It says that somewhere?

Ms Gotlieb: Section 8.

Hon Mrs Caplan: The director for cause can revoke a licence. If the director for cause moves to revoke, there is the opportunity for appeal to the the health services board, which would ask questions of the director as to what the cause was and determine whether there was sufficient cause to revoke the licence.

Mr Reville: Just so that everybody can catch up to this accurate explanation—I agree it is accurate—section 8 refers to the board. The definitions refer to Health Facilities Appeal Board, which sounds different than the Health Services Appeal Board you just mentioned, I might point out. But it is the same board?

Ms Gotlieb: Actually, there are two different boards.

Mr Reville: Now I am confused.

Ms Gotlieb: The board that hears the decisions on issuing licences, revocation of licences, renewal of licences, is the Health Facilities Appeal Board. Under this bill, there is also something called the Health Services Appeal Board, I believe, which is the same as what is under the Health Insurance Act; that is to hear decisions made by the director to set off against a physician where that physician is charging a facility fee. That is equivalent to what we presently have under Bill 94.

Mr Reville: Are there are two boards, or is there one board with two names?

Ms Gotlieb: There are two boards really. The primary board is the Health Facilities Appeal Board.

The Chairman: Would it be possible to get a chart?

Mr Reville: It would be really neat to have a chart. If you could indicate on the chart which kinds of appeals go to which, so we could sort it out, those of us who are visual in orientation would then understand, probably. I am not alleging that I am visual in orientation. Thanks. Sorry to interrupt. Carry on.

Ms Barnes: The other role we envision from the district health councils is to actually jointly issue the request for proposals with the minister. The council would hold a local meeting whereby anyone interested in submitting a proposal under the RFP—that is what we call the request for proposal—could come and meet with ministry staff and discuss the specifics of the request for proposal. Then the councils would be asked to review and rank the responses to the request for proposals, as they review and rank proposals for new and expanded hospital-based programs and the other types of programs. They make a recommendation to the minister, who then would make a decision upon whom to issue the licence to.

Mr Reville: This might be a better question for Ms Mauro, but I

imagine there exists somewhere in the ministry a map of the district health councils, too, and the areas they cover; and as well, the composition of the DHCs, the staffing complement for each, Metro being the biggest, I guess, but if I recall, some district health councils have a couple of staff and some have more. Then there are some areas not served by DHCs, and I am not sure why that is.

Hon. Mrs. Caplan: Ninety per cent of the population of the province today is served by DHCs. There are, I think, three areas—

Mr. Reville: York region, it strikes me, is one that is not, by some fluke.

Hon. Mrs. Caplan: York region and Prince Edward-Hastings, and there is one other, the Timiskaming area, I think. They are looking right now at the development of a DHC.

Mr. Reville: Would the intention be that each area of the province have a DHC eventually?

Hon. Mrs. Caplan: It is my view that having a DHC offers the community the opportunity to do its own planning. The district health councils are the official planning bodies of the ministry, and as their mandate is changing—as I have said, we have been discussing this over the course of the past year, so that they will have a renewed mandate—I believe that communities across the province will see the benefit of having district health councils.

Here comes Debi Mauro. Welcome. I am glad you were able to make it.

The Chairman: Please take a seat.

Hon. Mrs. Caplan: I was just referring to the changing mandate of the DHCs. A map of where they are and the composition can be made available to the committee.

The Chairman: For the record, we should indicate that Debi Mauro has arrived. Thank you for answering our request to be here today. We are sorry you cannot be here next Tuesday, but we understand you have important business out of the province.

Mr. Reville: Better earlier than later, in my view, so I am glad you are here. You should identify yourself for the record.

Mrs. Mauro: I am Debi Mauro, the executive director of the health planning division with the Ministry of Health.

Mr. Carrothers: Thank you, Mr. Chairman.

Mr. Reville: Mr. Carrothers, I am going to pick on you if you do not stop picking on me.

The Chairman: We started the discussion on the role of district health councils. Unfortunately, you have not heard what we have talked about to this point, but would you like to open with a few comments? Basically, we asked you here to answer questions. If you have some opening comments—

Mrs. Mauro: Okay, just a couple of comments. District health councils are volunteer health planning bodies. They are composed of 40 per cent

consumer, 40 per cent provider and 20 per cent municipal representatives. They come together to look at health planning needs for their regions. There are 28 district health councils in the province at this point in time and that represents approximately 90 per cent of the population of Ontario.

Mr Reville: How do you get on a DHC? You have to be a part of these percentages, presumably. You have to be a consumer, a provider or a municipal rep.

Mrs Mauro: Right.

Mr Reville: Is this by appointment by the minister?

Mrs Mauro: It is by order in council recommended by the Minister of Health. In practice, nominations are sought from a variety of constituents locally. The district health council looking for membership will advertise in local newspapers, the various media, radio and television, and will seek nominations. They will interview the candidates and recommend their best advice on who should be members of the council to the Minister of Health. The Minister of Health then makes representation of recommendations to cabinet.

Mr Reville: Does each district health council have the same number of members or does that vary?

Mrs Mauro: It will vary, depending on the size of the district.

Mr Reville: From how many to how many?

Mrs Mauro: There are 15 to 21 members per council.

Mr Reville: And likewise, the staff complement depends on the size of the region, the catchment area?

1610

Mrs Mauro: For the most part. District health councils have a small staff. There are usually two professional staff—by that, I mean professional planning staff—and two support administrative staff. There are two exceptions: Metropolitan Toronto, because it is a very large area to plan for, and Ottawa-Carleton has a larger staff complement.

Mr Reville: The establishment of a DHC in terms of staff would be what? An executive director?

Mrs Mauro: That is correct.

Mr Reville: Is that a management kind of person or a health kind of person, or both or either?

Mrs Mauro: Both. The individuals who are executive directors are experienced in the health care field.

Mr Reville: Then some clerical support staff.

Mrs Mauro: There is usually a senior planner, sometimes called assistant executive director, with health planning expertise, and then usually a senior secretary and an administrative person.



Mr Reville: Has there been any contemplation of beefing up these staffs, given the increasing—For instance, we know that district health councils are going to be more involved in planning community mental health, in terms of implementing the Graham report. There are additional responsibilities for this legislation. The government has indicated that in general terms, it wants to hear more from district health councils. Does that suggest to you that they have to have more staff?

Hon Mrs Caplan: What has been contemplated, and this has been a discussion I have had with district health councils, particularly the chairmen, across the province, is that resources come in many different forms. The intention is not to build large bureaucracies across the province. The intention is to look at what the needs are.

Many district health councils through project funding—The practice has been in the past and is today that they find expertise from other health planning sectors. They work together and there are opportunities through sharing of information, through information systems, through access to numerous kinds of resources, support from the University of Toronto in attaining the kinds of skills—

This is seen as a volunteer board. I believe strongly that they should have appropriate support, but there is always a concern I have that we simply look at what appropriate resources are to meet those needs, rather than coming in with a preconceived notion of what the staffing infrastructure should look like in advance. Those discussions are ongoing. The commitment we have made is that the district health councils will have resources appropriate to meet their new mandate.

Mr Reville: Minister, I do not have a preconceived notion of what the appropriate staffing complement should be. But all of us here have served on voluntary boards, some of us until we think we are going to droop. We know how frustrating it is to have a task and not have the resources to complete the task, particularly if you are volunteer trying to reflect a community need, but you may not be a professional. You are not a doctor, a nurse, a psychologist or something, and you want expert advice and it is just not there.

Hon Mrs Caplan: One of the strengths of the district health council is the 40 per cent consumer around the table, and the 20 per cent local government representative, which really, in my view—and the reason I am so supportive of the district health council process—gives a balance of professional and provider interests, consumer interests and the interests of local government as well. The issue of how they are supported differs, I would say, from community to community, as DHCs operate in a number of different ways.

One of the things I have discussed that I think you will find of interest is that much talent is available in local communities from individuals who are willing and able to participate in subcommittee structures to give expertise. We are encouraging that as much as possible, because we believe that there is much talent in the community that can be accessed for the district health councils in a way that will allow citizens to have greater participation in the planning process.

Mr Reville: It is a good principle. Theoretically, the split between consumers and providers appears to be appropriate. Consumers may or may not have actual power, and that depends on how well supported consumers are, it seems to me. The consumer is always going to be at a disadvantage when

confronted by a professional; that is just the way it is. It depends how strongly they feel, whether they say, "That's a crock, doctor," which might be quite appropriate under some circumstances. Traditionally people do not do that, although some do. That is the only point.

I guess the other question is in terms of how people get to be there. It sounds as though in some cases the process might well attract candidates who are wonderful, and then they are appointed eventually, through an order in council.

Have you had a chance to look at some of the other methods of finding your representatives: an evaluation, perhaps, of the community advisory board approach that some local boards of health have, where people are actually elected in their own community? Has that ever been contemplated? Is it considered to be dumb or fruitless, or whatever?

Mrs Mauro: It certainly has been discussed in the last eight to nine months when we have been looking at the future role of district health councils, but at this point the councils themselves wish to remain volunteers and continue to be advisory to the Minister of Health. That has been their initial response.

Mr Reville: But it surely does not go to the question of volunteer?

Mrs Mauro: As far as their role is concerned, because if all of a sudden they are elected officials, their role does change.

Mr Reville: Then you have to decide whether you should pay, that sort of question. Do you give per diems to people who serve?

Mrs Mauro No.

Hon Mrs Caplan: They get expenses only.

Mr Reville: So that cuts out poor people.

Hon Mrs Caplan: Expenses are covered; and what we find is that employers usually have been very good—

Mr Reville: It does cut out poor people.

Hon Mrs Caplan: —about allowing for the participation of their employees. Many of the meetings are evening meetings as well, and meetings are generally open to the public, so people can participate.

Mr Reville: Poor people cannot afford to volunteer in the same way that—I serve on a lot of groups where we have professional representatives. They are psychologists. They get paid \$80,000 a year to do what they give a lot of their time, during the day, for voluntary kinds of groups that look at planning. There is a lot of them who do that.

If you are on minimum wage and you cannot get that kind of time off work, you cannot do that. It is a well-known problem for people who do not have a professional income and a professional lifestyle. I will give you some papers on it if you want to look at it some time, because it really is a serious problem when we are trying to deal with, say, ex-psychiatric patients, who sit on a committee with a psychiatrist and a psychologist, both of whom are being paid by their employer to be at this meeting, but the consumer

representative is not being paid. Right? He is taking time off work.

Hon Mrs Caplan: I very aware of the point of view Mr Reville makes, and it has a lot of sensitivity. However, the experience in most cases, as I understand it from speaking with district health council members, is that employers have been very co-operative about allowing their employees at whatever stage, although there have been some questions—

But the fact that many of the meetings are held in the evenings permits broad access to participation. The district health councils have numerous subcommittee structures where, while the demands may be a significant time commitment, again, most of those subcommittees meet in the evenings. They also volunteer their time on weekends.

However, it is the practice for members of district health councils to have their expenses paid and have no per diem. In many ways, I believe this is very appropriate, because it maintains the voluntary nature of those boards. The councils themselves have, as Debi mentioned, restated the voluntary aspect as being an important one, because they come without any interest other than the community interest.

I should comment as well that the providers on the district health councils have also often left the interest of the group, association or employer at the door, and that the dynamic around the district health council table is a collaborative planning effort.

Having said that, that is a generalization. There are, of course, exceptions as you see how the different ones operate, but I wanted to make that point as well.

1620

Hon Mrs Caplan: There is one small thing I would like to say, because I think this is significant. This was a policy change: In the past, municipal councils had made a point of appointing individuals who were not elected members of the council. Because I really felt it was important for the local councils to be aware of the work of the district health council, we have asked now that the municipal councils appoint elected representatives.

Mr Reville: Has that happened already?

Hon Mrs Caplan: That is beginning. As appointments come up, we are now asking that the individuals who are the local government representatives be elected officials. That is a significant change, because that helps to maintain the provider-consumer balance. It also permits for the local councils to have access and information to an understanding of health planning in their communities.

Mrs Mauro: Just one other point on access to council meetings: The district health councils, generally speaking, represent a fairly wide district. For example, Cochrane District Health Council is Timmins, Kapuskasing, quite a wide geographic area up to James Bay. What that council does to provide better access is rotate meetings to various locations, so that more people attend the meetings.

Mr Reville: It travels around. I ran into that health council somewhere when it was travelling in the Cochrane district.



The Chairman: The travel costs are covered for members?

Mrs Mauro: Yes, they are.

Hon Mrs Caplan: You might find it interesting that the community advisory boards for the psychiatric hospitals are looking at the appointment process of the district health councils as a model of how they would like to improve the process for appointment to the psychiatric--

Mr Reville: I do not want to get sidetracked off into that issue just now.

Hon Mrs Caplan: I understand, but I wanted you to know that we are--

Mr Reville: But I have very large concerns about it.

Hon Mrs Caplan: I thought you would want to know that we are looking at governance and the board issue to make sure that these community groups are reflective of the community and that there is advertising and access for people who have a genuine interest in health planning. Many of the councils are now advertising on the basis of no experience necessary for their consumer representation, so that people will know that everyone should be taking an interest in the work of the district health councils.

The Chairman: Mr Reville, I have Mrs Cunningham who wishes to ask a question.

Mr Reville: I have finished. I just want to ask Mrs Mauro if there were any initiatives related to Bill 147 that are under way with respect to the DHCs. Is there some developmental work being done to help them deal with this bill?

Mrs Mauro: Definitely. There is a joint ministry and DHC working group to develop criteria for assessing need within a community and also when they are reviewing proposals within their community.

Hon Mrs Caplan: Marsha mentioned as well work that is going on at the University of Toronto to make sure the DHCs have the skill and the process necessary.

Mr Reville: Can any written materials prepared for that be made available?

Hon Mrs Caplan: I do not know what there is, but certainly.

Mr Reville: I would appreciate that.

Mrs Cunningham: What is the term of office for the representatives on the health council?

Mrs Mauro: It is a maximum of six consecutive years for any council member.

Mrs Cunningham: One term for six years?

Mrs Mauro: It is usually two years each term, renewable up to six years maximum, so three terms.

Mrs Cunningham: What is the process for electing a chairman?

Mrs Mauro: The members of the council hold a secret ballot among themselves and make the recommendation to the Minister of Health, so it comes as a recommendation from that council.

Mrs Cunningham: In your experience, are chairmen there for two years, four years, six years? What seems to be the norm out there?

Mrs Mauro: The norm would be two years usually for the chairman; it usually ends up to be the last two years of his or her term. Generally speaking, you get a fairly experienced council member who has had two to four years' experience as a council member moving into the chairman's seat.

Mrs Cunningham: What is the turnover? Do you find people normally do their three terms, or are you looking at some problems with councils changing entirely every six years? How is it working?

Mrs Mauro: It staggers the appointment process so that you do not lose an entire council in one year. It is a turnover of roughly a third per term, so you always have some experienced people on council.

Mrs Cunningham: Did the staggering start at the beginning or is it something that has been developed during the last couple of years?

Mrs Mauro: We have some councils that have been in existence since the early to late 1970s, so their procedures are well established. Some councils, like Muskoka and Parry Sound, are very new; they are one to two years old. It is in development. It will vary depending on the maturity of that council.

Mrs Cunningham: I was not aware of the staggering at all and that is why I am asking the question.

Mrs Mauro: I see. It is staggered.

Mrs Cunningham: That is good.

Mrs Mauro: It is very important to have that kind of history.

Mrs Cunningham: The continuity is extremely important.

How many members of any particular council could also be members of hospital boards?

Mrs Mauro: For the most part, chairmen of hospital boards are not members, because that could be perceived as a conflict of interest in some cases or just because of the demands of their other jobs; but certainly we do have former chairmen of hospital boards on councils, as we have former district health council members who are now board members of hospitals.

Mrs Cunningham: Do you have any council members who are also board members? I do not mean board chairmen; I mean board members.

Mrs Mauro: I would have to check that. For the most part, they would not be active board members of a hospital.

Mrs Cunningham: Are there any rules around this, or is this

something that is just a rule of thumb? Does it say who cannot be? I would not expect that would be said.

Mrs Mauro: No, but there are conflict-of-interest guidelines that have been developed with the district health councils and that is policy within the councils as it is within the ministry. We have an administrative manual that lays out these policies and practices for district health councils.

Hon Mrs Caplan: Maybe we could make a copy of that available to all the members of the committee, if they are interested.

The Chairman: I would be interested.

Mrs Mauro: Certainly.

Mrs Cunningham: If the health council is looking at integrated delivery of health services—and I am assuming that the mandate is to assist in the delivery of the integration of health services for any one community or region—what role does a hospital board play?

Mrs Mauro: The hospital board is a very important group that the district health council works and consults with. The Minister of Health mentioned that there are subcommittee structures within each district health council, and they do a lot of the work in needs assessment and in recommending health priorities. So each district health council does have an acute care or hospital committee. On those subcommittees you will find members of hospital boards and/or hospital staff and chief executive officers of hospitals who would provide advice to the council.

Hon Mrs Caplan: That was one of the vehicles I mentioned for accessing the kinds of expertise that is out in the community and available to the DHCs. I think it has worked quite well.

Mrs Mauro: Yes, it has.

Mrs Cunningham: I am assuming a subcommittee is made up of members of the board plus others; is that what you are saying?

Mrs Mauro: Usually what happens is that the chairman of a subcommittee is a council member. All other members of the subcommittee are not council members. They will come from a variety of backgrounds. If you are looking at the hospital subcommittee, you will usually find board members and staff of hospitals on those subcommittees, but the committee is chaired by a council member.

Mrs Cunningham: I am sorry to be so specific here, but I am interested.

Mrs Mauro: That's fine.

Mrs Cunningham: It is one quick way of not having to read something. With the subcommittees, if you have a board of 15 or 21 people and subcommittees, are we looking at four or five subcommittees per health council? Have you got a norm on that one?

Mrs Mauro: I have a lovely slide presentation on all of this. It is too bad I could not bring it; I think you would have enjoyed it. It lays out all the subcommittee structures. There are usually six subcommittee structures now.



Mrs Cunningham: Which would allow six members of a council of 15 to 21 to be on the subcommittee?

Mrs Mauro: Yes, but there are also other ad hoc committees and special task forces that can happen at any given time where council members may be asked to participate, such as the committee we have right now looking at this piece of legislation.

Mrs Cunningham: Basically everyone who is on this council would sit on some subcommittee or advisory committee?

Mrs Mauro: Yes.

Mrs Cunningham: This is a lot of work. Their mandate has just been extended with this bill. Correct? That is going to take some time.

Mrs Mauro: I think that if the volunteers were here, their response would be, yes, it is a lot of work, but as long as it is time well spent, they do not mind giving the time. It is amazing the amount of time they volunteer and how hard they work to do the work for the ministry.

1630

Mrs Cunningham: I know some of them and I have spoken to them, so I am aware of that. Thank you. I have no comments to make. I am just pleased with your responses. I hope they are all working.

The Chairman: I believe Mr Philip has a supplementary.

Mr Philip: It is supplementary to what both Mrs Cunningham and Mr Reville were asking. I guess one of my concerns is that when I look at the structure we now have in place, I see that we have a structure that may work well for a lot of people but it does not always gather input from those people who may be highly articulate, but not necessarily in English. I am talking in my case of the Spanish-speaking community and those who speak Urdu, Punjabi and Hindi, who may have tremendously sophisticated organizations of their own but do not feel comfortable in the kind of structure that we Anglo-Saxons have developed over the years.

Now, you talked about subcommittees that will be involved in trying to outreach and get information and so forth. Are there any other models that you are developing to involve the leaders in those communities who are not necessarily medical practitioners, psychiatrists, dentists and other what I would call professional health care givers in the community?

Mrs Mauro: Certainly in such a culturally diverse area as Metropolitan Toronto that is something, and there are others of course. That is a very important issue that has to be dealt with. District health councils are also challenged with that kind of culturally sensitive issue that they have to look at and get to the table and discussed. I think the district health councils have to represent their community-----

Hon Mrs Caplan: And reflect their community.

Mrs Mauro: And reflect their community, thank you. Certainly we have developed with district health councils guidelines for council members to have a more multicultural representation, and certainly with their subcommittees too, so we are heading in that direction. District health councils are aware

and are working with leaders in their communities to get that kind of involvement in council matters because it is very important.

Mr Philip: I guess what I am getting at is that it seems to me --and I think it is something that our particular political party has had to grope with as well in developing---that the traditional model that we are used to in the way in which we hold our meetings and organize our society and so forth may be quite different from what some of these people are used to. That does not make them any less articulate. Many of them are articulate in their own kind of culture. We would feel perhaps as uncomfortable if we were transposed into those societies as some of them feel fitting into ours.

I guess I am concerned that if our structure does not fit, then there should be other ways of getting the information in a way that they feel comfortable with and that they can have the input. If you do not, then you are going to have the Scarboroughs and the Rexdales and places like that, which are providing services but not necessarily the services that those people need based on their experiences and the medical or healing or health models that they may be used to that may be quite different from ours.

They say politicians should not ask questions unless they know the answer to them. I do not know the answer to it, but I am just asking, is there anything new that you are developing in terms of new models that will help the health councils get into those communities and assess those needs that we have not done with our traditional parliamentary kind of structure?

Mrs Mauro: Certainly making district health councils aware of the issue, to be sensitive to the needs of multicultural groups is a first step, but I recognize that is not the only thing one can do and one should do more.

With the subcommittee structure in Metropolitan Toronto, I know at the mental health subcommittee in Toronto there were some issues around providing services for Oriental people. There was quite an effort that started to get people from that community involved in assessing the needs of their community and inputting into the actual proposal development. It does not have to be a structured committee setting.

Visiting with some of the leaders and getting that input is the way that that subcommittee started and it seems to be working, so the consumers come to the table and feel comfortable in articulating what their needs are for their community. So that is another approach. But it is going to take a while for all of us to become more culturally sensitive and we have to keep reinforcing that in every discussion, every policy decision, every new program. That is an issue that we have to ask ourselves and question, "Are we reflecting the needs of the community that we serve?" So it is more a planning question as well as a program development question for our communities.

Mr Philip: One last question. Both the provincial auditor and the standing committee on public accounts have turned out what I think, with all due respect, was an interesting report on mental health services in this province and it is an ongoing study. I have had feedback from different professionals and from, quote, the "organized ex-patient" or the "organized user of psychiatric services," the various groups. I have not had any feedback, as the chairman of the committee, at least they have not called me, from the district health councils.

I am wondering whether or not you feel there is any leadership role which the ministry can play in making these councils aware of some of the

concerns of the provincial auditor and of the public accounts committee and seeing what input they will have into solving some of the problems that were identified in that report: the ex-patient who "gets lost out there," and results in the revolving-door kind of syndrome that we were so concerned about. I do not want to go into all the litany of the problems we have pointed out, including some of the housing problems, but those general areas, which I know you are familiar with through the report: Is there a leadership on the part of the ministry in getting that kind of concern, not just in the top echelons of the ministry, but also down to the grass-roots level?

Mrs Mauro: I would rather say a partnership between the ministry and district health councils. The framework referred to as the Graham report, the blueprint for mental health services for the province, was a joint planning effort between the ministry and the community. A former district health council chairman actually chaired that group: Bob Graham. The district health councils are working with the ministry right now in implementing that framework and the district health council is represented at the table, as am I, as the district health council representative within the ministry. So we are very involved. That planning framework that was developed for councils in their communities to plan and implement mental health services is thought of very highly by those councils and they are working diligently to implement that report in their local communities.

Mr Philip: It will be interesting to see what the next audit turns up on that.

Mr Reville: The community advisory boards or the psychiatric hospitals: How do they link in to DHCs and Graham? Do they have a formal link?

Mrs Mauro: Yes, they do. With the mental health committee, subcommittee of district health councils, both community advisory board members and psychiatric hospital staffs sit on those subcommittees.

Mr Reville: Of the DHC?

Mrs Mauro: Of the district health councils.

The Chairman: In some cases it would involve more than one DHC, would it not?

Mrs Mauro: Yes.

Mr Reville: Yes.

The Chairman: Because I know Hamilton Psychiatric Hospital relates into the Brantford catchment area and we have our own DHC.

Mrs Mauro: Yes.

Mr Reville: That sounds right; good.

Hon Mrs Caplan: Would the record note—do you want to say that again?

Mr Reville: That sounds right; good. We will look a bit dumb but will say it twice.

The Chairman: I do not see any further hands, so on behalf of the committee, thank you for making that special effort to get down here in a



hurry and answering all of our questions.

Mrs Mauro: Thank you very much.

Mr Reville: Thanks very much.

The Chairman: The committee stands adjourned until 10 o'clock tomorrow morning. Please be on time: a gentle recommendation.

The committee adjourned at 1641.

CA20N  
X012  
-S78

S-14a

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

INDEPENDENT HEALTH FACILITIES ACT, 1989

TUESDAY 15 AUGUST 1989

Morning Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Dietsch, Michael M. (St. Catharines-Brock L) for Mr Daigeler

Hosek, Chaviva (Oakwood L) for Mr Beer

McGuigan, James F. (Essex-Kent L) for Mrs O'Neill

Reville, David (Riverdale NDP) for Mr Allen

Smith, E. Joan (London South L) for Ms Poole

Clerk: Decker, Todd

Staff:

Drummond, Alison, Research Officer, Legislative Research Service

Witnesses:

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriole L)

Sharpe, Gilbert, Director, Legal Services Branch

MacMillan, Dr Robert, Executive Director, Health Insurance Division

From the Canadian Abortion Rights Action League:

Rowe, Robin, National Co-ordinator

Pearl, Leslie, Board Member

From the Immediate Care Walk-In Clinic:

Zacharias, Dr Ramesh, President

Heseltine, Dr Geoffrey N., Medical Director



LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 15 August 1989

The committee met at 1008 in committee room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: The committee will come to order. This is a meeting of the standing committee on social development, convened to consider Bill 147, An Act respecting Independent Health Facilities. We are in our third day of public hearings and we have two delegations this morning, the first being the Canadian Abortion Rights Action League. Representing that organization are Robin Lowe, national co-ordinator, and Leslie Pearl, a member of the board. Welcome to the committee.

You have half an hour for your presentation and that hopefully will include some time for questions from committee members. I think the committee would appreciate an opportunity to ask questions.

CANADIAN ABORTION RIGHTS ACTION LEAGUE

Ms Rowe: It is Robin Rowe, actually, from CARAL.

The Chairman: What did I say?

Ms Rowe: You said Lowe.

The Chairman: I am sorry. I misread it.

Ms Rowe: The first small point I want to make is about the cover sheet you should have that summarizes our recommendations. There was an error. We left out one of our most important recommendations, recommendation 3, in our text and recommendation 5 was duplicated, so items 5 and 6 are the same. Please substitute recommendation 3 for one of those.

The Canadian Abortion Rights Action League, or CARAL, is a national pro-choice organization established in 1974. The goal of CARAL is to improve access to contraception and abortion services, including counselling, across Canada.

CARAL supports the establishment of free-standing clinics to perform abortions, especially when they provide abortions in the context of other reproductive health services. We see such clinics not only as an alternative to most hospital abortions, but as one that offers a number of distinct advantages, both in costs and in qualitative services to women.

Abortions performed in hospitals use precious operating room time and are often done under general anaesthesia. This latter procedure means increasing the number of doctors and nurses who must be involved in the procedure. In clinics, general anaesthesia is not used and one doctor and a

nurse use a regular room, properly equipped for a vacuum and extraction abortion. Immediately, there is a large saving in the taxpayers' health bill in insured services, operating costs and capital costs.

In addition, the use of local anaesthesia by clinics reduces the risks to women associated with the use of general. Clinics also use the safest and most up-to-date abortion techniques, such as the suction D and E, or dilatation and evacuation, procedure instead of the more invasive saline technique for second trimester abortions.

Furthermore, the psychologically supportive atmosphere is beneficial to women. People who work in these facilities have made a commitment to total reproductive health care for women.

CARAL has always stressed the need for counselling, both pre- and post-abortion, for the woman, and if desired, her partner. Naturally, birth control information is part of this counselling and an integral part of these clinics. These latter two services need not be provided by a doctor. Trained counsellors or nurse practitioners are the appropriate personnel for these positions and the best use of our health care dollars.

Access to abortion services in Ontario has long been acknowledged as being inadequate. In Dr. Marion Powell's January 1987 Report on Therapeutic Abortion Services in Ontario, it was confirmed that too many Ontario women needing an abortion have to travel outside their county of residence to obtain one, despite the fact that medically speaking abortion is one of the simplest surgical procedures there is.

More than 50 per cent of all hospital abortions in Ontario are performed in Metropolitan Toronto. I think another important statistic is that fewer than half of all Ontario hospitals offer abortions. Ontario women more than 12 weeks pregnant have the most difficulty in finding an abortion. These are available in hospitals in only eight of the provinces, 49 counties and in the three free-standing abortion clinics in Toronto. Dr Powell pointed out the international trend towards most abortions being performed outside of hospitals and recommended that access in Ontario be improved through strong government initiatives.

Since the Powell report, we have had the 1988 Supreme Court of Canada decision in the Morgentaler case, recognizing women's right to access abortion outside of hospitals. Now we have the Ontario Independent Health Facilities Act, which is supposed to provide a vehicle for the minister to develop community-based health facilities through which medical services traditionally associated with hospitals may be performed.

Abortion is probably the most controversial of services appropriate to the community-based clinic model. The question CARAL has is, how will this legislation actually affect access to abortion in Ontario? Are we confident this legislation will be used to encourage, not curb, the provision of abortion services outside of hospitals? The answer is no.

Our concerns are rooted both in the political attitude towards nonhospital abortion services exhibited by the government and the specific provisions of this proposed legislation. The bill is structured in such a way that the government will have to be proactive if it wants to improve access to abortion. It cannot leave it up to the local district council to show the necessary political courage.

The government has made no policy statement committing itself to using the vehicle of this legislation to encourage the provision of abortion, along with other reproductive health services, in all the communities in Ontario, nor has it even acknowledged that such services are better provided outside of hospitals. With no such commitment that the process established by this bill will be used to improve access to abortion services, and considering the way it is written, we are concerned it could become a dangerous weapon against the provision of abortion services in Ontario.

For instance, under this bill the Minister of Health can stop the Morgentaler and Scott clinics from operating, even though the challenge by these doctors to perform clinic abortions was upheld before the Supreme Court of Canada.

Our first recommendation is that the province issue a clear commitment to fund nonhospital abortion and other reproductive health services and to ensure their provision in communities throughout Ontario.

Now I would like to go through the specific provisions of the bill that are of concern to us.

We note that the proposed legislation refers to operating and administrative costs that will be set by regulation, but there is no reference to capital costs. If this government is serious about nonprofit clinics that are community-based, it will have to provide capital costs to establish these clinics. Without the availability of capital cost payments from the province, nonprofit community-based clinics will not be available.

Our second recommendation is that the province include in the proposed legislation the possibility of capital cost applications for nonprofit community-based facilities.

Canadian Abortion Rights Action League is concerned that under the proposed legislation the only method whereby the Minister of Health will receive proposals for independent health facilities is by invitation of the minister. We understand that the ministry proposes to discover the need for such facilities by consulting with the district health councils, but we fear this method may be subject to pressures not related to health concerns when it comes to the provision of abortion services.

The Powell report, commissioned by this government, acknowledged the pressure that is executed by antichoice, antiabortion groups on health care providers in an effort to keep the latter from supplying abortion services. CARAL has seen this battle for control of hospital boards over this issue in this province, as well as in others.

It is therefore essential that the proposed legislation not be unduly restrictive in identifying areas of need for independent health facilities. Allowing for proposals to be submitted independently of any call by the minister would open the process and give the ministry fresh independent views of areas of need, which could then be submitted to its review process.

Our third recommendation is that CARAL recommends that the legislation allow for proposals for independent health facilities independent of any call for proposals by the minister. This is the recommendation that was omitted from the summary.

CARAL applauds a proposed amendment to the act that provides for reasons



to be given by the director of independent health facility when any proposal is approved or refused. That is section 8. The provision of such reasons will help to ensure that decision-making is free from personal or political bias.

We are concerned, however, that other safeguards are missing from the Independent Health Facilities Act. For example, the act allows for those facilities already in operation at the time the legislation is enacted to apply for a licence without a call for proposals from the minister; that is section 7. Should such a facility be refused a licence, however, it would be in the same position as a person putting forward a new proposal. The facility that had already been operating would not have the additional protection afforded to facilities threatened by revocation, suspension or nonrenewal of their licences. Again, we are particularly sensitive to potential political pressures and/or personal biases regarding abortion clinics that fall into this category.

So our fourth recommendation is that before a licence is refused to a facility that has been operating prior to the Independent Health Facilities Act coming into force, the facility should be able to request an assessment. In addition, the facility should be able to appeal a decision of the Health Facilities Appeal Board to the Divisional Court.

We note that where the minister directs the director to not renew a licence, the legislation does not require that written reasons be provided. I am talking here about section 18. Without such reasons a facility will not know the case it has to meet in petitioning the Lieutenant Governor in Council to revoke such a direction. We also note that in section 9 the minister may direct refusal to issue a licence without providing reasons therefor. The requirement to supply such reasons will help to ensure that the decision is free from personal and/or political bias.

Our fifth recommendation is that where the minister orders the director to refuse to issue a licence or directs the director to not renew a licence the minister should be required to provide written reasons to the licensee.

CARAL understands that the provisions regarding evidence before the Health Facilities Appeal Board are fairly standard for administrative tribunals. Because of the dangers inherent in the admission of hearsay evidence, however, we are concerned that appeals from the board to the Divisional Court are limited to questions of law. This means that a decision could be made to revoke a licence based on incorrect factual evidence and this would not be appealable.

## 1020

Recommendation 6: CARAL recommends that decisions of the Health Facilities Appeal Board be appealable on questions of fact or mixed law and fact as well as on questions of law alone.

CARAL is concerned about the tremendous powers given to an inspector under the act, particularly the power to search and seize patient records. Patient confidentiality has been of increasing concern in recent years as we have seen breaches in such confidentiality despite oaths such as that provided for in this act. We believe that patient records should be searched only when there is good reason to believe that the act is being contravened and that such records would reveal evidence of that contravention.

Recommendation 7: CARAL recommends that inspectors should only be accorded search and seizure powers under a warrant of the court.

CARAL was most pleased to see the proposed amendments to the Independent Health Facilities Act which will leave "medical necessity" in the definition of "insured services" under the Health Insurance Act. The removal of "medical necessity" from the Health Insurance Act would leave all medical procedures open to the political party in power to determine if they are necessities. Thus, procedures such as abortion and sterilization, to name but two, are vulnerable to being struck from the list of insured procedures due to the moral or political whim of the party in power. CARAL was appalled at the idea that medically necessary procedures might not be covered by Ontario's health insurance.

The Independent Health Facilities Act has a grandfathering clause for clinics established prior to 2 June 1988. We understand this clause does not guarantee these clinics licences in the future.

Toronto now has three abortion clinics, which might at first glance seem to be a large number for this one area. In considering whether to licence these three clinics, it should be recognized that presently they are serving women from all regions of Ontario, and in fact from other provinces, especially Atlantic Canada.

Until similar services are available throughout Ontario and the rest of Canada, these three clinics are providing vital access to abortions for Canadian women who need them. The out-of-province service provided by these clinics may require fees being charged to these patients. We are pleased to see provisions for these changes in the proposed amendments.

We note that one of these clinics was not in operation on 2 June 1988, so we recommend that the legislation's cutoff date of 2 June 1988 be changed to the date the legislation is given royal assent.

The Chairman: Does that conclude your presentation?

Ms Rowe: Yes, it does.

The Chairman: Thank you very much and thank you for leaving some time for questions.

Mr R. F. Johnston: It has been of some concern to me for a long time that the legislation is so ambiguous about its intent around women's health clinics and I note a lot of your comments were based around this concern. But you seem to be giving a sort of benefit of the doubt to the government on this in that all you are asking for is a government position that would say that it is interested in expanding the facilities around the province from the three that exist at the moment, whereas I interpret its lack of specificity about the need for these clinics and a clear mechanism that makes it easy for these clinics to be established as a statement that in fact it wants to use this legislation to stop expansion of these facilities. Otherwise, I do not see any reason why not.

In other words, you seem to be being, in my view, more generous with them than I would have expected. At this stage, has the minister been saying things to you behind the scenes that would make it seem that her point of view, rather than that of Mr Sweeney, or members on this committee who are

antiabortion, is holding sway and that we are going to see an expansion of these facilities?

Ms Pearl: I guess we have given the ministry the benefit of the doubt. We see this legislation basically as enabling legislation, providing the mechanism whereby independent health facilities can apply for a licence, although, as we have indicated, we are disturbed by the very narrow circumstances under which they can apply for a licence: namely, that the minister has to call for proposals first. We are very concerned about that, but we have taken the legislation at face value basically as enabling legislation. That is why we are concerned that we get a verbal commitment from the ministry on its intention.

We would be happy to hear any suggestions you might have to make as to things that might be incorporated into the legislation that would make it clearer that the government has the intention to facilitate access to abortion in this province.

Mr R. F. Johnston: I do not see this as enabling legislation in a clear-cut sense at all. I see it as a real double-edged sword kind of legislation, which puts enormous power into the hands of the minister and, on this kind of issue, where that individual's moral point of view might hold sway.

Yes, Mrs Caplan's point of view has been made clear in past elections around her pro-choice position, but there is no guarantee, as we have seen recently, that people are going to stay in cabinet for ever. A shift puts enormous power into the hands of an individual whose own particular moral bias on this matter might overwhelm things and change things totally, even if you got Mrs Caplan's point of view today.

That is what scares me about this legislation. I do not see it as straightforward and enabling at all. I see it as both enabling and incredibly potentially restrictive in this area. Given Mr Sweeney's comments about this, as you may recall, at the time of it being first tabled, where he saw this as the tool to make sure there were never going to be any more independent health facilities set up for women in the province, I have real concern about this kind of approach.

Perhaps the minister can tell us something today in response to your request that would clear that up and make it clear that individual whims of ministers are not going to be used to use this legislation to stop the expansion.

Hon Mrs Caplan: I think we have been very clear, not only in statements in the House but during question period, that our approach to the delivery of women's health services is a comprehensive approach. In fact, we have not been supportive of single-purpose facilities, but the whole approach of women's health centres is to make sure that reproductive health is incorporated with all aspects of women's health. That has been a very clear approach.

This bill is not procedure-specific. It acknowledges that there are many procedures. We have had Dr Stein talking about the advances in eye surgery. There will be others talking about orthopaedics and others. This bill acknowledges that changing medical practice and changing technologies can allow for many procedures and services, formerly only able to be done in a quality-assured environment, in a hospital, to be able to be safely and appropriately provided in alternative settings.

This bill allows for the orderly planning and expansion of providing appropriate facilities in appropriate locations, on advice of district health councils, to assure a quality environment with the ability to ensure that appropriate services are delivered in appropriate locations right across the province.

This bill is not service- or procedure-specific. It acknowledges the changing environment of health care and technology. The government's position on the provision of services, whether they be for women or any other group in society, I think is clearly stated as part of government policy at any particular point in time.

Mr R. F. Johnston: If you are reassured by that, Carol, I would suggest that I have some land in Florida that I would like to sell you.

Why can you not give a specific commitment, Minister, especially as somebody who has been on the record as being pro-choice in the past? It is not just even a matter of you being moved as a minister and somebody else coming in who is not in favour of pro-choice. This is long-term legislation which another government could be administering with a very different philosophy around questions of choice.

Is this going to be used as an active vehicle to allow women to get clear access, when the information is laid out by Carol and known to us all about the inadequacy of facilities and hospitals around the province? It is quite clear. Is it going to be used positively or not?

You have just given me a lot of healthspeak, as my colleague says, and nothing around the specific question and specific concern of those of us who want to see those facilities expanded and not reduced.

1030

Hon Mrs Caplan: I think it is important to state again that this bill is not procedure- or service-specific. It is framework legislation to allow for the expansion of appropriate community-based facilities in a quality-assured environment. Regardless of what the service or procedures are, the same process applies for the appropriate planning and delivery of those services.

I think the overall government commitment to provision of appropriate services in a quality-assured environment is what this bill is all about and that is what we should be discussing in this committee, certainly concerns of any individuals or groups or organizations, acknowledging that there are many procedures that can be provided in alternative settings and acknowledging that we need to have the kind of framework that will allow for quality of care and a comprehensive approach.

Mr R. F. Johnston: This is going to be the only vehicle they have now. When you bring in this legislation, this is the only vehicle by which a clinic to provide abortions will be able to be established, and you are giving them mealymouthed answers about the possibility of getting this. Since the Supreme Court ruling, have you had one district health council in the province of Ontario suggest to you that it needs an independent facility in its area? Have you had one?

Hon Mrs Caplan: We have no vehicle now to have that discussion because we have no act.



Mr R. F. Johnston: That is not true.

Hon Mrs Caplan: We have no act in place today that would allow for the discussion in any community about what kind of appropriate facility might be planned that was not part of this act.

Mr R. F. Johnston: By playing Sunday shopping with the health councils and sending this back to each health council now to, you are suggesting, come forward under this legislation with some proposals, do you really think you are going to get a large increase in the number of independent health facilities coming forward? Mrs Smith nods as if that is going to happen. I would think it is just going to be the opposite. They are not going to want to take on that political battle locally; they are not getting any direction from you and this legislation is giving them a clear out. They are saying, "The minister has not called for anything, so we are not going to bring anything forward." It is an easy copout.

The Chairman: We are getting into a debate.

Mr R. F. Johnston: Of course we are.

Hon Mrs Caplan: I just want to point out that the process permits the minister, where need is determined, to go with requests for proposals seeking the advice of the DHCs.

Mr R. F. Johnston: Given what is happening in Canada at the moment, women deserve a clear answer from this government at the moment and not the mealy-mouthed kind of stuff we are hearing today. If I were CARAL at this moment, I would say that you should be demanding that this become very specific legislation and not legislation which is as holistically incomprehensible and incomprehensive as you are saying it is.

The Chairman: I am conscious, as chairman, that the time of the delegation is being used for an exchange. I think it has been an interesting exchange, but—

Mr R. F. Johnston: I just wanted to clarify.

The Chairman: —it is your time, Ms Pearl, to have a chance to comment in reaction to that exchange before I go to the next questioner, if you wish.

Ms Pearl: I think Mr Johnston has been expressing our concerns very well. Some of the things that might be done by this government to indicate the kind of commitment we are talking about are indicated in some of our proposals such as opening up the process so that persons or groups, community-based groups, could make proposals independent of any call by the minister for proposals. We should not have to sit back and wait for someone else to determine if there is a need. We have been saying there is a need for a long time, and I do not think we should have to be dependent on the political process in such a sensitive area as this.

Mrs Cunningham: I have two or three questions. We will stay on the one about the district health councils advising the minister. I am looking at this as enabling legislation as well, notwithstanding Mr Johnston's comments, which I very much appreciate, but I want to take the high road on this and see if we can make it work.

I share your concern about the district health councils always being able to advise the government as to where the real needs are across the province of Ontario in sort of a co-ordinated way. I am not sure how that will work. I am sure the minister has thought about it. How else do you think the government should get its advice, in what other way? If we are looking at procedures and real need, not only for abortions but maybe cataracts or knees or whatever, how would you do it? How would you get the advice other than from the district health council? Where else can they go? What kind of waiting list can they look at? Where could they consolidate this information?

Ms Pearl: One of the things we are suggesting is that the procedure for receiving proposals be opened up. I think one very good way of measuring need is by proposals from persons or groups who are prepared to go in and provide the service. They are not going to go someplace where they feel there is no need for the service. That is probably one of the more accurate ways in which you are going to be able to measure that need.

There may have to be other means of identification where, for instance, you are not dealing with a profit-making service, where you are dealing with a nonprofit service. Certainly with groups like ours or in an area like this, you can receive information from all kinds of places, from us and others who are tracking the situation and hear from women in the various areas of the province as to their needs.

There are many sources of information, and I do not think the minister should be dependent solely on the district health councils.

Mrs Cunningham: Just for your information, if one wants to start up a nonprofit child care facility in Ontario, individuals do individual needs assessments, provide them to the area offices of the ministry, and they come up that way; so I think your point is well taken. All we are trying to do in this committee, of course, is to make this legislation better, and the minister can get some other ideas for improvements, I hope. Thank you for answering that question.

My next one has to do with nonprofit, given that we stay with this nonprofit approach. Of course, many people before the committee do not like this approach at all. They think if medical services ought to be available to the public, they ought to be able to pay, but that is another argument. In nonprofit, I am very curious, because I share your concern. Are you a nonprofit group now?

Ms Pearl: Me?

Mrs Cunningham: Not you, the clinics that you are aware of. Are they nonprofit?

Ms Pearl: I believe one is nonprofit and two are not.

Mrs Cunningham: It is a very curious thing to start up something government-driven in this sense with no money for capital. Again, child care facilities do get capital grants to get started from time to time, as appropriate. How would you start something in a nonprofit manner if you did not have capital? Who is going to pay for it?

Ms Pearl: That is exactly why we have suggested that nonprofit groups must be able to apply to the government for capital cost payments as well. Without them, we just do not see nonprofit clinics being able to operate.

Ms Rowe: And the legislation should be changed to specify that.

Mrs Cunningham: What is your definition of "nonprofit"?

Ms Pearl: I cannot say that we have one.

Mrs Cunningham: I think the government is going to have to look at that. The minister should underline "definition of nonprofit."

Hon Mrs Caplan: There is a definition in the act.

Mrs Cunningham: There is one?

Hon Mrs Caplan: I believe so, yes.

Mrs Cunningham: Perhaps you could look at that and answer my question at a later time with regard to your---

Ms Rowe: It is not in the definitions that we have here.

Mrs Cunningham: Maybe you could tell us where it is, because I must have missed it as well.

Hon Mrs Caplan: I know that we have been discussing definitions, and I hope at the appropriate time we will have an opportunity to discuss that.

Mrs Cunningham: Okay. Perhaps you could do your homework and I could do my homework and we could advise the government as we see fit on how a nonprofit group could get started, if in fact this whole thing is centrally driven with no opportunity to make any money or raise any money except through the nonprofit sector. Most of us are not happy with bake sales any more; we gave those up a long time ago.

You are quite right, to call something nonprofit and to say "You are not going to get any assistance with capital" is a real concern, but all of us are trying to be somewhat positive and provide alternative suggestions. I would appreciate that or any other assistance you can give to us in our position of trying to help the government improve the bill. Thank you very much.

1040

Mr Jackson: Perhaps I could just put a finer point on that question. If the district health councils are going to be responsible for determining need and making a presentation, whether there is a proposal call or not, and if the legislation is silent on capital support that helps start a nonprofit, it is the custom now in Ontario that some of that seed money be provided on a regional basis through regional government, through some of their community services committees and the funds they create for some health moneys.

Do you foresee a problem where the focus for the debate within the community to obtain additional local funding would be centred in a community and not with the provincial government, where it might more rightly be, in terms of getting some of the capital funds necessary to open a clinic?

If the government does not respond to your recommendation to provide seed capital, then you have to find it somewhere else. In many health institutions, one of those areas is to go to the regional government and say, "We need 20 per cent financing, so we are going to come to you for seed

money." That becomes a political commitment at the regional government or municipal level, as opposed to one at a provincial level.

Do you foresee that as a complication in terms of your advocacy work, in terms of garnering support from a regional council and having them vote as to whether your proposal gets even to a district health council recommendation stage, because there are no local moneys to assist the clinic to open?

Ms Pearl: I think your point is well taken. While we would have mixed feelings about this, because of course we would like to see community involvement and support, we feel that on a widespread level there would be community support for abortion or reproductive health service clinics. But obviously, sometimes that is a very sensitive issue politically, and it can be very difficult for people to be forthcoming about their support for it, depending on their community and how vociferous anti-choice groups are in that community.

You are quite right in saying that if such a facility needed to turn to a regional government for seed money, that could make it all the more difficult for a facility to become operative, to be able to get under way. As a result, I think that alternative must exist whereby such a proposal for capital funding could go to the province directly.

Mr Jackson: There has been one sort of political tag put on this bill by at least one or two members calling it a sort of Sunday shopping approach. I have been sort of reluctant to suggest that, because I did not see the elements of that in this bill. Local decision-making is local decision-making. But on volatile issues where the community is badly divided, it does fall within the gamut of being classed as a Sunday shopping style approach—in so far as the tough issue of whether a community should have Sunday shopping is being decided locally—where the tough decision as to whether the community should have an abortion clinic would be decided locally.

This is not an issue. You are not going to get people coming out with placards because they are wanting to open a child psychology centre, a residential centre for battered wives and so on. In that sense, I think this is the one small area within the legislation which might lend itself in an awkward and inappropriate manner to ongoing debate.

My second question—and I will be brief—has to do with the concept of facility fees. I have tried to ask questions of every clinic that has come before us, "Do you currently charge a facility fee over and above OHIP, or are all procedures currently occurring in the clinics in Toronto based solely on the OHIP payment?"

Ms Pearl: We are not a clinic.

Mr Jackson: I understand that. To your knowledge, do the clinics that are here before charge a facility fee over and above that which is separate and distinct?

Ms Rowe: Yes, they do.

Mr Jackson: You understand that this legislation is an effort by the minister to gain control, in a sense, of that facility fee so that those expenses do not run at large and Ontario citizens do not have to pay for those.

Ms Rowe: Yes.



Mr Jackson: Are you aware of, and can you enlighten the committee, whether there is a differential facility fee for American residents or non-Ontario residents? I do not have that information. I just wondered if you knew the answer to that question.

Ms Rowe: I do not know.

Mr Jackson: I do not know; perhaps we will get that information. But each of the clinics we have talked to to date deals with non-Ontario residents, other Canadians and also  
S-1045-1 follows  
pack 3 begins

Mr Jackson: Are you aware, and can you enlighten the committee, whether there is a differential facility fee for American residents or non-Ontario residents? I do not have that information. I just wondered if you knew the answer to that question.

Ms Rowe: I do not know.

Interjection.

Mr Jackson: I do not know. Perhaps we will get that information, but each of the clinics we have talked to to date deals with non-Ontario residents, other Canadians, and also deals with Americans. I want to get a better handle on this issue, because in yesterday's hearings we put a very fine point on some questions about the percentage of procedures which are occurring within a facility which are for Ontario residents and the number of procedures occurring for nonresidents, because that can affect the profitability of the operation. You can well imagine that if you have more procedures for Americans who pay in American dollars at a higher rate, then the facility can reduce its financial picture if it is in a negative position.

Ms Pearl: You will have to speak to the clinics about this, but it is certainly not our understanding that they are marketing to the American market, as it were, or attempting to market outside the province in order to increase their business.

Mr Jackson: No, but you are a national organization and your advocacy is a national approach, and therefore the clinics in Ontario are a venture for other provinces which are not evolved to the level that Ontario is in terms of accessibility in abortion procedures.

Mr Reville: On a point of order, Mr Chairman: There are three clinics coming before us the next few days. Why does he not ask them?

The Chairman: I am not sure that is a point of order. I was about to mention to Mr Jackson that we do have one other committee member who wishes to ask a question; we are over our half-hour, so I would like to get that. Would you like to comment briefly?

Ms Rowe: The only comment I wanted to make was that access to abortion in Ontario is such that women often have to travel to the United States to access an abortion. The flow is not the other way around.

Mrs E. J. Smith: I want to comment, first, that it is rather interesting that we are talking about health facilities and we are using tongue depressors to stir our coffee. It is quite appropriate.

However, in a more serious vein, I am concerned that we may all be putting different interpretations on the word "capital" as being used by the members opposite for clarification. It is used differently in so many acts and bills. I could say, for instance, that if your main function in a health facility were destroying kidney stones, capital would be a very fancy machine, whereas in an abortion clinic it might be more the facility itself, and so on and so forth.

I would like some clarification as to how proposals deal with capital, because I assume that however you interpret it, we have to at least be dealing with it. Second, I wanted to commend Mr Jackson when he said that it would seem that the bill wants to—I think I am quoting him correctly—gain control of the facility fee so that they can better serve the people of Ontario. I think indeed you sum up very well something we all want to achieve; I just wanted to make that comment, that I have no problem with seeing that. But I would be very interested in some clarification of capital.

Dr MacMillan: The request by the presenters, of course, is that it be written in the statutes. From the very outset, we have always recognized that in order to encourage nonprofit organizations to apply, we would have to have some consideration of capital in some way. For instance, the minister in moving in that direction within the last year has allowed capital for community health centres in the province, which is not written in statutes, yet the money is there.

We are now developing with the fiscal branch the opportunities for various groups according to their status on what moneys they would be able to generate. Obviously, once one receives a five-year licence that will obviously be associated with considerable income to support the services, that in itself provides collateral, so often the financing might be able to be done by the nonprofit group without the assistance of government directly.

Hon Mrs Caplan: All of the issues around need for capital, whether the capital is actually bricks and mortar, machinery or equipment, are parts of the ongoing discussions within the ministry about where the capital resources of the ministry should be able to be utilized to support the provision of services. As you have heard, we have moved to allow for capital funds for community health centres. In the past, we have used capital funds, as you know, to support hospital infrastructure. The whole discussion from the policy point of view is under debate right now and, as you know, the minister stands accountable during estimates for the use of all of the ministry funds and particularly capital resources.

1050

Mr Pearl: I am still not clear; I am sorry. You have clearly written into the legislation the fact that operating fees are going to be part of the payments by the province, that there will be payment for operating fees. You are going to be taking over the facility fee currently being charged by some of these facilities. Why is it that the possibility of capital payments is also not written into the legislation?

Hon Mrs Caplan: Initially, when we approached the bill, the view was that the facility fee would reflect the depreciation of equipment and the overhead costs of the facility over the course of the five years. As Dr MacMillan stated, that would be collateral. There was the possibility of ministry policy, in a permissive sense, being able to consider those kinds of requests.

We have had the discussion here at the committee and I have said that we will certainly be open to listen to the kinds of representations that are made. What I would also recommend, given the fact that a number of your questions are technical, legal questions, is that you meet with the director of our legal services, Gil Sharpe, who is here beside me, to discuss your recommendations. Perhaps through the clause-by-clause we could discuss those which may be appropriate.

The Chairman: That concludes the questions from the committee. Do you have any brief concluding remarks before we go to our next delegation? No. Thank you for coming before the committee and sharing with us your perspective on this bill.

Mr Jackson: Before the next deputants assemble, could I request information from legal services with respect to point 3 raised by CARAL? That is the basis on which an appeal can be launched without knowing the grounds for which a licence was denied. That is an interesting legal question and perhaps we could have a fuller, later explanation as to how that can occur. I just serve notice.

The Chairman: The next delegation is Immediate Care Walk-In Clinics. Representing that organization we have Dr Ram Zacharias and Dr Geoffrey Heseltine, medical director. Welcome to the committee. Who will be making the presentation?

Dr Zacharias: I will. I am Dr Zacharias.

The Chairman: You have approximately 15 minutes for your presentation and hopefully there will be time for some questions.

#### IMMEDIATE CARE WALK-IN CLINICS

Dr Zacharias: Three weeks ago when I was asked by a representative of the Ministry of Health if I would like to appear before this distinguished committee and make some comments about Bill 147, it appeared to me be analogous to the village idiot trying to tell the townsfolk how to run their business. In order to better understand my views on this particular act, I believe it would be important for me to take the first few minutes to give you a brief résumé.

I consider myself extremely blessed, because I was born in a Third World country and exposed to that environment. I was fortunate enough to have had my education in two of the leading academic institutions in this country and finally receive my medical training both in Canada and in the United States. Having been exposed to their various systems of health care, I am grateful for the outstanding system that exists in our province.

I consider myself primarily a physician, with my business interests of a secondary nature. My business interests consist of provision of physicians to a number of hospital emergency rooms throughout this province, as well as owning and operating three medical walk-in clinics. We are committed to the provision of cost-effective quality health care.

In the 13 years since I entered medical school, I have had the privilege to witness that which was once considered miraculous now being treated as mundane. During my general surgery training at the University of Western Ontario in London, Ontario, I was fortunate enough to have assisted in the surgery and post-operative care of a number of liver transplants.



We in this province are extremely fortunate to have some of the brightest and most dedicated physicians and nurses. It is our collective responsibility to create an environment where these individuals are allowed to flourish.

I have tried to assess the Independent Health Facilities Act from the viewpoint of a physician as well as that of an entrepreneur. Whatever the motivating factor, I believe this government and this Minister of Health, along with individuals in the Ministry of Health, need to be commended for this first step.

The free enterprise system, which is the foundation that has made this country great, has for too long been excluded from playing a role in providing health care. The stress of technological advances, coupled with ever-increasing demands and expectations from the public, are inflicting a mortal wound on our finite health care budget. It is no longer acceptable to rely on unilateral decisions on the part of either politicians or physicians to implement change.

This legislation claims to recognize the possible contributions which can be made by private enterprise in solving this crisis. On the other hand, it proposes an implementation and control system heavy in bureaucracy and administration. Although the need to provide responsible reporting to funding agencies is laudable, excessive control is usually anathema to all entrepreneurial sectors.

This partnership will survive only if each party respects the skills contributed by the other and accepts the small idiosyncracies of the partners. These differences can be hidden strengths which will rise to meet future challenges. If these differences are ignored, they may doom the IHFA to inertia, failure and eventual oblivion. As it now stands, this legislation will not encourage the type of participation desired by the government from the business sector. It could even be considered regressive by the application of its various restrictions.

I would now like to take time to highlight some of the concerns I have with the act.

With regard to establishing the independent health facilities, part of my business also involves international trade that requires travel to various countries. There are two points I would like to make. First, it is my experience that incompetence is not limited by national boundaries. Second, profit is not a four-letter word. The fact that the applicant is wholly Canadian owned and a not-for-profit organization in no way ensures competence, nor does it ensure the success of the enterprise.

Preference should be given to groups with majority Canadian ownership.

You folks were asking what a definition of profit is. To me, profit is simply a tool to recognize success of a venture and should not be rejected when requesting assistance from the private sector.

I have some concerns about the procedure to obtain a licence. I feel applications to open clinics to provide needed services should be accompanied by letters of support from the local medical community as well as the public at large. These applications should be submitted with an application fee to cover the costs of assessing the proposal.



Special application review boards need to be established to hear each application. These boards should consist of representatives from the following groups: I believe there should be representation from the Ministry of Health, from the Registered Nurses Association of Ontario, the Ontario Public Service Employees Union, physicians of the appropriate specialty, the Ontario Hospital Association, local politicians and, finally, there has to be representation from the general public. After all, that is the only reason we are here.

The burden of proof should rest on the applicant. The ministry would review the board's recommendations, after which the successful applicant should be allowed to complete the project. There should be no tendering of the concept.

The preferred duration of licence should be outlined not by the ministry but by the applicant. Licences restricted to five years are a deterrent, since they do not allow adequate time to amortize the capital costs of land, building and equipment required to operate a health care facility.

Licences should be transferable with written prior approval from the Ministry of Health. The need for a health facility in a community cannot be removed simply through mismanagement by its operators.

With regard to loss of licence, accreditation should be granted to clinics on the same basis as hospitals and monitored in a similar fashion. The ministry might consider the use of a receivership-style team to administer clinics not deemed to be maintaining acceptable quality standards. The final report would determine whether the licence should be revoked. It would also allow proper consideration of accurate conditions rather than permit quick, unsubstantiated judgement from a remote body.

I have deep concerns, as I am sure a number of you have, with regard to the power of the director and minister. It is acknowledged that a final authority is necessary to adjudicate disputes and make decisions in difficult cases. I would suspect that a board with a broad mosaic of experience, yet still aware of changes to the strategic direction of health care in this province, would better serve as a final authority.

#### 1100

We are entering a challenging period in the development of health care delivery in our province. The task is not insurmountable, yet it would be much easier if the entire health care community worked as a team rather than adversaries. Although we represent but a small segment of the health care community, we have developed two complementary business ventures well accepted by local physicians, hospital administrators and the general public. We provide ambulatory services presently offered by hospitals. We use cost-effective methods while maintaining consistently high standards. After initial reluctance, there has been overwhelming support of our clinics from both patients and informed local politicians.

As I close, I would like to end on a personal note. During the course of preparing this brief, I talked to a few individuals who had experience in the political arena. I claim to be a total novice and am much more comfortable in the operating room than this chamber room. It was their opinion that, at best, I had less one per cent chance of influencing the decisions of this committee.

Their unbridled pessimism brought to mind two incidents in my own life. It brought back memories of 1967, when my father was a 55-year-old East Indian

immigrant trying to seek employment in this country. After each unsuccessful attempt, there were those who suggested to him that he was not employable. It took him three long years of constant effort before he was hired, initially to just answer telephones at a produce order desk. At the age of 65, when people his own age were being forced to retire, my dad was promoted to the directorship of one of the largest corporations in this country. I am glad they were wrong.

I also think back to the summer of 1974, when I sat across the desk from one of the deans of a medical school in this province who said to me: "Mr Zacharias, you will never get into medical school. You should go out and find another career." I am glad to tell you he was wrong.

I do hope that you will give some consideration to the changes proposed by us. I sincerely appreciate this privilege and let me reiterate the privilege that has been mine, afforded me this day, to share some of our ideas with you and commend this Minister of Health and this government on this first step.

The Chairman: Thank you very much for your presentation. We have some committee members interested in asking questions, beginning with Mr Carrothers.

Mr Carrothers: You said something, when you were talking about the five-year licence and the question of amortizing equipment, about five years not being long enough. I was just curious. It had been my experience that normally, equipment—Maybe what I am asking is: What equipment would you perceive being in a facility that you would not amortize over five years, as I thought that was the normal period over which these things are depreciated?

Dr Zacharias: It would depend on the type of clinic and what sort of equipment you are talking about. If you are talking about expensive arthroscopic stuff or if you talk about, as Mrs Smith has raised, about lithotripsy units and things like that, it varies. There is some equipment where the capital cost is very small and five years would be adequate. I think the onus should not be on the part of the ministry but should be on the part of the applicant as to how long they feel is an appropriate time to amortize their equipment.

I think the proof of burden should lie with the applicant. They should be able to prove to you and me and the guy on the street that they need five years or they need three years or they need 10 years, but to restrict it to five years unilaterally I do not think is an appropriate time period.

Mr Carrothers: Does not this equipment—in tax law anyway—fall in that range of equipment where you would be claiming your capital cost allowance against income at the rate of 20 per cent a year? In other words, you would be, for tax purposes anyway, writing off that equipment over five years, claiming it against your income. It would seem to me that that would be a fairly logical matchup for this kind of licence.

Also, are not most types of equipment basically being rendered obsolete? I may be extrapolating from my own experience with nonmedical equipment, but it seems to me that most equipment I have ever seen used or used myself in business has tended by the end of five years to either be worn out or be rendered obsolete. Therefore, you would be replacing within a five-year period, not 10 years. I have trouble thinking of a piece of equipment actively used in a business you would write off over 10 years, and I guess that is why I was asking the question.

Dr Zacharias: The concerns I had were that by restricting it to five years, you are etching it in stone.

Mr Carrothers: The tax laws do that already in a way, do they not? The clinic would be doing that for its own tax purposes anyway.

Dr Zacharias: I cannot answer that question.

Mr Carrothers: That was really all.

Mr Owen: I am not very familiar with this concept of walk-in health care clinics. I just want to get some clarification in my mind if you could explain some few basic things to me. For example, is the type of service you are providing duplicating what the family doctor would be doing or is it quite different from it? Is the kind of service you are providing duplicating what our emergency services are providing or is yours quite different? What I am concerned about is is there duplication or is it quite separate and distinct and therefore needed by itself?

Dr Zacharias: Okay. If you look at any studies done of patient flow through emergency departments in this country, and it does matter what the region is, it is very different than in the United States. I have practised in the United States, and the patient who comes to emergency in this country is quite different from who goes in the United States, because of the costs involved in going to the emergency department there. At least 60 per cent, if not 70 per cent, of people who come to the emergency departments across this province can and should be looked after in a much cheaper facility.

To look after somebody who has had a laceration or has got a sore throat in an emergency department that has all this fancy equipment is analogous to trying to hit a fly on a wall with a sawed-off shotgun when a fly-swatter would do. I think walk-in clinics are a much more cost-effective way of providing the services, if you could educate the people to use the facilities appropriately.

In our clinics we do two things. One is that we try to work closely with the family physicians in our community. We do not do any follow-up in our clinics. We basically compliment what the family doctors are doing and would like to lessen the burden on some of the emergency departments. When we see patients, no costs are passed on to the patients. We charge strictly whatever the OHIP fee for the physician's assessment would be. When a patient goes to the emergency department, there is a fee that is transferred on to OHIP other than the physician's fee.

There is no literature that I am aware of—maybe it does exist—that has shown that walk-in clinics increase the cost of health care. There are emergency departments that I work in in this province right now where over the last two years—and they have no walk-in clinics in the community—the percentage increase in volumes is almost 35 per cent to 40 per cent. There are no clinics within 60 miles of these places and yet the patient volumes through those emergency departments are up on average about 35 per cent in the last two years.

I think the concept of clinics can lessen the overall health care costs if people are educated to realize that the emergency departments should be treating emergent cases and the ambulatory nonurgent cases can and should be looked after in a cheaper facility.

Mr Owen: Why not the family doctor then?

Dr Zacharias: Because in the majority of the cases the patients who do come to us—in our clinic in London family doctors do send patients to us. When they cannot see patients and a patient comes to them, they will send them to us.

Mr Owen: Okay. The next, and latter, part of my question is, what do you bill? Is your billing just for your OHIP charge itself?

Dr Zacharias: That is correct.

Mr Owen: Do you have extra charges for equipment?

Dr Zacharias: No, we do not.

Mr Owen: Do you have any extra—

Dr Zacharias: None.

Mr Owen: Just what you bill?

Dr Zacharias: Exactly as if you walked into your family doctor's office. There are no costs passed on either to OHIP or to the patients.

Mrs Cunningham: I have a couple of questions. First of all, I did not influence you in any way and yet I am the member for London North.

The Chairman: There is noise outside. Can you speak up a bit?

Mrs Cunningham: Me speak up? Wonderful.

The Chairman: I am having trouble hearing you, Dianne.

Mrs Cunningham: I do not think I have ever in my whole life—yes, I will.

Mr Carrothers: There is always a first time.

Mrs Cunningham: I do not think Mrs Smith influenced you in any way with your comments today either, did she?

Dr Zacharias: No.

Mrs Cunningham: Okay. We were not part of this team, but I am very happy that you have come to present your position before the committee. I think everybody shares your concerns. If, as an experienced businessperson, you are telling us that there are some serious flaws, one should listen.

I need a clarification. Do you consider the services that you are providing in your clinic to be something that will have to come under the auspices of Bill 147?

1110

Dr Zacharias: Not at the present time because we, in fact, do not charge an administrative fee to the government at all. So we would not be affected by Bill 147. It is my understanding that is the case.



Mrs Cunningham: So you clearly consider yourself a profit-making group, of course.

Dr Zacharias: It would be reasonably fair to say that.

Mrs Cunningham: You told us not to be afraid of the word, so I am not afraid to ask you, so do not be afraid to tell us.

Mr Jackson: He is not that uncomfortable in a political environment with an answer like that.

Mrs Cunningham: Some of us would like to think that we could make some profit some day.

Basically, the money that you would be making in your clinic would be because people are working hard and in fact billing OHIP.

Dr Zacharias: It is basically the volume.

Mrs Cunningham: Yes, volume. Physicians never like to talk about this, but they do make money. All right? And they are making money somehow and some of them consider if they want to see three patients a day, they are not going to make any money. If they want to work hard, weekends, nights, the whole thing, they make money. That is what this whole system is about.

Dr Heseltine: Volume and the fact we are open from nine o'clock in the morning until nine or 10 at night.

Mrs Cunningham: That is right. And weekends, I am assuming.

Dr Heseltine: That includes weekends.

Mrs Cunningham: Exactly.

Dr Heseltine: Seven days a week.

Mrs Cunningham: If you were to expand the services of your clinic, given the needs as you see them—you work in the middle of a very busy community—what kinds of services would you expand into? Could you give us an idea? What else would you like to do?

Dr Heseltine: We have looked into several other types of facilities and we looked into an athletic injuries type of clinic. We also looked at the costs of doing that, providing adequate physiotherapy and the adequate equipment for that. The initial costs were quite horrendous. It got to the point where we did our whole business plan and then backed off, partially because of the initial cost and partially because we found the people who were going into the clinic decided that the profit was not there. We may see it way down the road, but we were not going to see it for years to come.

Dr Zacharias: I, personally, do not foresee myself pursuing any ventures under this bill. I have enough headaches as it is. This is speaking as a physician and as a businessman, but if I were to comment on it, I think there are certain procedures that are done in a hospital that can in fact be done more cheaply outside, whether you talk about arthroscopic procedures or the ophthalmologist doing cataracts, or gastroscopies, endoscopies or whatever.

I have worked in emergency departments and probably in this province I

have more privileges than any other physician in this province. I have privileges in 15 hospitals and I work all the way from Windsor to Ottawa, in some small communities, St Catharines, Toronto, all over. I see gross abuses of emergency departments whether it is patients or physicians in terms of running clinics through them. I think it would be much more effective to take some of that stuff out of the emergency departments into the private sector and into the community. I think the people will be serviced well.

The American health care system has great problems but I think there are certain aspects of it that we can learn from just like we can learn from the Japanese and whomever. I think we, as physicians, need to be able to service the people a little better. A four-hour wait in an emergency department I do not think is appropriate. If you are on holidays travelling through Muskegon, you do not want to spend four hours in the emergency department to have your kid sewn up. That is the norm in a lot of places and it is because the system is plugged up with nonemergency cases.

We can also go to the extreme of saying: "Why provide more service? The more service you provide, the more utilization." Mad magazine in the early 1970s was asked to do a survey on how to make baseball games more interesting. One of the conclusions was to only have one hot dog vendor throughout the whole park so you spend all your time trying to find the guy to buy your hot dog from and ignore the game. Is that one way of making a ballgame interesting? Do we back up the emergency cases so that people decide "We are not going to go if I have to wait four hours"?

Mrs Cunningham: You stated that—

The Chairman: I would like to draw to your attention and to the committee's attention that we have gone over the 15 minutes and that we still have five members of the committee who wish to ask questions. I am in the committee's hands. Do you wish to extend the time to allow for questions? We have extra time this morning. Is that agreeable?

Would you continue then? I just wanted you to be aware there are five other members.

Mrs Cunningham: I will make it quick and will just say that it is discouraging to hear an entrepreneur and a professional come before the committee to say that he would not do it. I am not being negative towards you; I am disappointed with the response we are getting to the bill, because the intent of the bill was to get a person like you to come in and say, "Look, I would really like to start up an independent health facility and do something with eyes or knees or whatever." Therefore I hope that the government is going to be listening to that.

I asked the other people before you to define "nonprofit" and would like to know, from your point of view, whether you can take time down the road to get in touch with me so I can present to the minister how somebody would get started on a nonprofit basis and the kinds of things that you think we need in Ontario.

Dr Zacharias: I think it is naïve to think that nonprofit should be a criterion, because you can vary whatever profits you want in administrative fees, legal costs, accounting or whatever. My personal feeling is that it is naïve to think you are going to gain by having nonprofit as a criterion for acceptance. If I could just make one comment on what Dianne Cunningham mentioned. I, in fact, applaud this minister for coming up with this

legislation. I think, like anything else I have learned—I have no business background—I have learned the hard way that you can have a very good idea but, if you have poor management and poor implementation, you will kill it. You can take a mediocre idea with good management and succeed. There is no question about that.

I think this is a good idea. The problem I have with this is in the way it is being implemented, and I think this is the way we ought to go. We need to get the private sector more involved in providing services. I just think the way the legislation is, there is zero incentive to get involved. I do not know if Dr MacMillan remembers; I was in on 7 November when they had the hearing and my comment was: "White man speaks with forked tongue. You have all these hoops that I have to jump through and then say I am nonprofit." But I think that does not mean the whole thing needs to be squashed. I just think that the idea is a very good one; there are changes that need to be made to it to make it attractive for people out there to get involved.

The Chairman: We will go to some of the other questioners, if they would all keep in mind that we are trying to fit five in and we are well over the 15 minutes. I realize we have lots of time this morning, but I do not want us to be perceived as being unfair to other groups when on other more tightly scheduled days we will be keeping strictly to 15 minutes.

Mr Jackson: I was pleased the point was brought out that walk-in clinics are not included in this legislation, but during Dr MacMillan's presentation he was careful to say, "Not at this time," and suggested that it was a rapidly growing field or service in this province and that we had gone from 44 last year to 88 this year. You are fully entitled to, and I respect your enthusiasm about, the bill in the context in which you are currently addressing it, but to what extent do you have concerns when and if walk-in clinics are determined first of all by need, by the district health council and by configuration by the DHCs and most of the hospitals which in and of themselves are suggesting that they are the predominant driving force within DHC decisions?

Dr Zacharias: I think the whole concept of walk-in clinics needs to be addressed in another area. There are certain criteria. I have on two occasions written to the Ontario Medical Association expressing an interest in being willing to serve with them in determining criteria. I have owned walk-in clinics in the United States and Canada, have yet to have a response from them for either of those two letters, but would be pleased to be involved in any procedure that is set up. I think you cannot let walk-in clinics run like wildfire. There has to be control; you have to think of the guy on the street. We are all taxpayers and have to get some control of this. My personal feeling is that we spend more than enough money on health care in this country. It is how we distribute the money that is important.

One of the problems with the walk-in clinic, it is true—and I have been in clinics long enough to know it—is that they do not generate all that much revenue. In fact, I have been approached on more than one occasion to buy other clinics and have had access to their financial statements; they are a total disaster. They were run under principles that violate any common sense or sense of decency and were driven purely from a profit mechanism.

I have been in clinics long enough to know that they do not generate all that much revenue. I make far more money as an importer of oriental rugs than I do in walk-in clinics. I think when these people have fallen apart, when they have asked me to look, it has been obvious why they went under. They had capital costs that were out of line.

I think we have to have some control over what is being provided to the poor guy on the street, because he is totally innocent, and it is your responsibility and my responsibility to do that.

1020

Mr Jackson: I was warned as a little boy by a spiritual adviser, "Be careful what you wish for; you may get it."

Dr Zacharias: That is right.

Mr Jackson: I will leave for Hansard your invitation for more regulation in walk-in clinics.

I have a technical question for the minister, just for my own understanding. We have a walk-in clinic operating in our community of Burlington. It has had a positive impact on the number of admissions in the emergency department, but I also have about 22,000 citizens in my community who are on a capitation HSO-type program. I guess I want just a quick answer. How does the ministry deal with those HSO patients who are on the \$14 per month to the doctor? They walk into the clinic and there is a billing. I understand the mechanism. Are we silent on that? How are we dealing with that, because it could represent a significant—

The Chairman: I think we are getting well off the topic we are here for.

Mr Jackson: I know we are, and that is why I am trying to be very brief, but it does have some implications to the direction of HSOs, which I quite frankly very much support.

Hon Mrs Caplan: Just to answer from a policy point of view, often the HSO, which is the health service organization, which is an alternative payment mechanism for physicians, will provide the kind of after-hours service as part of a program.

Mr Jackson: This one does not.

Hon Mrs Caplan: I am going to ask Bob MacMillan to respond from his perspective.

Dr MacMillan: With respect to this act, nothing will be different. If a patient registered with an HSO accesses an independent health facility, there will certainly have to be a recognition that that patient is going outside the HSO and some type of negation will have to be built in so that is the way HSO physicians understand and operate and therefore are encouraged to provide evening services and house calls and so on. I do not think this act is going to jeopardize that program.

Hon Mrs Caplan: The assumption of the health service organization is that the continuum of care and the co-ordination of that care is offered by the health service organization to the person who joins the roster.

Mr Jackson: I just want to know if there is a debit.

Hon Mrs Caplan: There is a debit; that is what negation is.

Mr Jackson: There will be a debit?



Hon Mrs Caplan: There is an offset, yes. It is called negation.

Mr Jackson: Okay, that is all I wanted to know. Thank you.

Mrs E. J. Smith: I realize we tended to get off subject, because in a sense the whole thing is off subject since you are outside the act.

Mr Jackson: Yes, but then the government invited them.

Mrs E. J. Smith: Yes, I know. I was going to say that I think none the less—

Mr Jackson: I think it is fair if we let them do that.

Mrs E. J. Smith: I think it is my turn, Cam.

None the less, I think we are all very interested in learning about your operation, so I would be happy to hear from you on some things for clarification for me, because although you are in my community I do not know your facility. However, being an occupant of Toronto a lot of the time, I walk by these clinics all the time here in Toronto and think to myself that since I do not have a doctor here I might go in.

Let me ask a couple of things. You obviously run several clinics, so you are in fact a manager and a good manager. Would the people in the clinics mostly be on salary?

Dr Zacharias: It depends on the clinic. Some of the physicians are paid on an hourly rate; some of them are paid on the basis of the number of patients they see or a percentage of their billings.

Mrs E. J. Smith: So by and large they are your employees one way or another, short-term or long-term.

Dr Zacharias: They are technically not our employees, because in fact the majority of them do work elsewhere.

Mrs E. J. Smith: From my business operating point of view.

Dr Zacharias: Sure.

Mrs E. J. Smith: You manage to work at a profit. Although you feel maybe it is not a satisfactory profit, still they all run at a profit due to your good managerial skill.

Dr Zacharias: I never complained about the profit.

Mrs E. J. Smith: I was interested in your comments that you work very closely with family doctors and tend to involve them. I had heard this about your clinics, that they tend to see you and get you as quickly as possible back to a family doctor, which is fine and dandy; I have no problem with that.

Just taking a rough guess, what percentage of the patients who come through your doors would you actually be able to deal with, treat and have them then satisfied that they do not just get referred on to some other facility? I guess I am trying to get a hold on to what extent you are almost a reception and referral group rather than an active treatment centre.

Dr Zacharias: Where I talked about the referral, I said that if a follow-up is required, we do not do it. If no follow-up is required, then I—

Mrs E. J. Smith: How do you define follow-up?

Dr Zacharias: For instance, if I see a child who has an infected eardrum and I treat it, it needs to be rechecked in two weeks to make sure the infection has completely settled down. That follow-up is done by the family doctor, not by us.

Mrs E. J. Smith: What if you do not have a family doctor?

Dr Zacharias: We have a list of about four or five family physicians who are taking new patients, and if this is a parent in the community who has just moved from Ottawa to London and is looking for a family doctor and his four-year-old child has an ear infection, we will treat that child and then give him the list of the four or five people who are taking patients.

Mrs E. J. Smith: I am just trying to get a picture in my mind of this operation. What percentage of your patients would receive treatment in your clinic that can only be done by a doctor, and this is an active treatment, rather than telling them that they need to see their doctor or this sort of thing, which maybe a public health nurse type group could do.

Dr Zacharias: I think it is no different from what comes into a doctor's office. I do not quite understand your question.

Dr Heseltine: We would treat the majority of patients, initiating treatment. However, if a patient needs a follow-up recheck to make sure that, for example, the child with the infected ear had recuperated and was fine, we would have a family doctor do that.

Mrs E. J. Smith: So you would never see the same patient twice for the same illness.

Dr Zacharias: Unless it occurred at a different time.

Mrs E. J. Smith: Yes, another illness. I appreciate your answer, but I find your hotdog analogy rather a non sequitur because I thought if the hotdog stands were giving away hotdogs free at the taxpayers' expense and making a profit, it would be a fair comparison.

Mr Jackson: That is like talking about the Americans coming up to watch our baseball.

Ms Hosek: The question I want to start with has already been answered, but I am not sure everyone heard. That is, you open from 9 to 9 every day and are available at hours when other kinds of medical care might not be available.

The next question I want to ask is whether you are able to measure the impact of your presence in the community on the utilization of emergency services in the surrounding hospitals. Can you tell, in any way that you can share with us, what impact the fact that you are available has on how much emergency service is being used?

Dr Zacharias: I think it is a very, very difficult way to assess. As I said, if you look at the overall utilization of emergency—and in the eight

years that I have practised emergency medicine, it is getting far busier than it used to be. This is even in communities that do not have walk-in clinics. I do not know how I would go about assessing it, to be honest with you.

Ms Hosek: You could not make a comparison about emergency services in hospitals near where their clinics are and their rate of increase versus emergency services in hospitals?

Dr Zacharias: There was work done in the United States that said it had no impact on the emergency departments, but comparing their system to ours is like comparing apples to oranges. I am not aware of any paper that has been done in this country to assess that.

Dr Heseltine: I think the utilization of emergency rooms is increasing substantially. We got figures from the Cobourg Hospital and a couple of others, and over the eight-year period that we received the figures, it had almost doubled, and those are communities where they do not have walk-in facilities. So it is very difficult to look at it in communities where they do.

Ms Hosek: To see if it has doubled in your community as well—then you begin to wonder exactly what it is you are measuring.

The other question I want to ask you is about the kind of work you do. Do you have a quality assurance program in place? Do you have some kind of clinical guideline that you are using internally now with the work you do or is it simply that you have trained physicians and they do what they do?

Dr Zacharias: We do. We have policy procedures for our physicians in terms of the follow-up and stuff like that, but in terms of how they treat various conditions, no.

Ms Hosek: You do not have a spot-check system where you sort of look and see how you are doing with the infections or whatever.

Dr Zacharias: No.

Ms Hosek: One of the difficulties I can see is that if your referrals are going outside, you might not be able to know if there is any kind of problem with the work you are doing.

Dr Zacharias: What we do is, if we do any sort of cultures, we get a copy of it and we also send a copy of the history sheet to the family doctor the next day, a courier cost borne by me. We are the only clinic in Ontario doing that; so if I saw you in our clinic, your family doctor would know the next day that I saw you and what I did; if I did a culture on you, he or she would get a copy of it as well.

1130

The Chairman: Did I hear you right: you are saying that as far as you know, other clinics do not follow this practice?

Dr Zacharias: As far as I know.

The Chairman: A walk-in clinic?

Dr Zacharias: That is correct. The original clinic was set up in

London and it started out as an after-hours clinic from 5 pm to 9 pm and on weekends. As the demand grew, we found there were people coming in all day. Right now, in one of our clinics in London, we see 500 patients a week and I think we have a number of family doctors who, when they go out on holidays, sign out to us. I cannot think of another clinic in this province that has that.

Ms Hosek: It sounds to me as if what you are doing is not only taking up the slack of emergency, but taking up the slack of the waiting time to see family physicians and that is why it is so hard to measure what your impact is on the overall utilization patterns of health care in our community. That would be my hunch.

Dr Heseltine: You are probably right.

Mr McGuigan: I have a supplementary to Mrs Smith's questions. I was concerned about the example of the child with the ear infection. Incidentally, I had an eardrum burst one time and the pain is worse than having a baby.

Interjections.

Ms Hosek: How do you compare?

Mr McGuigan: I think it might be like it. It is the worst pain I ever had in my life.

Mrs E. J. Smith: I agree. I will accept that.

Mr McGuigan: I am speaking from the position of a member who comes from a rural community. Most of our doctors' practices are closed, or we cannot get doctors to come in; whatever carrots we offer to them, they do not come.

What happens to that child if he was treated in your proposed clinics in Chatham, London or Ridgetown and you referred him to a doctor, but you could not get a doctor or refused to get a doctor or something like that, and the child comes back to you two weeks later and the infection has flared up again? Do you treat the child or what would happen in that situation?

Dr Zacharias: Yes, we do. You see, the advantage of having two weeks to book an appointment is there is really no reason why this individual cannot get that child to the family doctor. We look after the immediate need and then there is sufficient time that they can do the follow-up.

But these people are not using their family doctors. We have certainly spoken to them about the fact that they do have a family doctor. The costs are the same in terms of whether they come to us or the doctor. So all we can do is tell them to go back to their family doctor. If they refuse to do it, there is not much we can do.

I will just take 30 seconds to say this: I had a patient, a female patient who had to have a pap smear done. I said: "We don't do them in our clinics. That's not good care. You need a family doctor who should follow you up and do that for you." She categorically refused to go a family doctor. She said: "I've spent years with walk-in clinics around this country. I don't need a family doctor." How do you force that woman out of your facility?

Mr McGuigan: So you did treat her?



Dr Zacharias: No, in fact, I told her to find a family doctor. Whether she went to another clinic and ended up getting a pap smear, Lord only knows. All I can do is advise them; whether they follow it, it is up to them.

Mr McGuigan: Maybe I missed the point, but again, on the child—

Dr Zacharias: If they do come back we will treat them, but I think what we try and do is educate them that this is not good medicine.

The Chairman: Dr Zacharias, the whole issue of walk-in clinics has been very interesting. It is somewhat off topic of the bill itself, but I think because it is such a new development, it is has been very interesting for the committee to hear your answers. Since we have strayed off topic, I think the committee will permit me one question, as well, off topic.

Mrs Cunningham: Mr Chairman, I do not think this has been off topic at all. I think he came to talk to us about the bill and has given us some real good suggestions.

The Chairman: The last few questions have been off topic.

Mrs Cunningham: If you got stuck with the title—

The Chairman: His presentation was on topic. He spoke to the bill.

Mrs Cunningham: Yes.

The Chairman: I was not criticizing his presentation at all.

Mrs Cunningham: I think there is a big message here.

The Chairman: In your business credentials at the back of the paper you have provided us, I was intrigued to read one of your operations is called Med-Emerg Inc. and it says here that you provide a service to 16 Ontario hospitals in the emergency room coverage. Is this on a contract basis to the hospitals to, say, supply emergency physicians in their emergency departments or how does that work?

Dr Zacharias: In 15 seconds, I will give you the background to it. When I was a second-year general surgery resident at the University of Western Ontario, I was doing some research and during the weekends I used to work in some of the small community hospitals like Strathroy and Wallaceburg to supplement my income. When I went back to do clinical work, I was approached by some of the hospitals as to whether I would try to organize a group of physicians to maintain this service, never intending it really to be a business, and got together with a group of six or eight guys.

To make a long story short, we provide physicians, as I say, to about 16 hospitals right now, some of which is just weekend work and some of which is weekday work. I have some contracts with hospitals. I have left it strictly up to the administrators and the physicians if they want contracts. If they are not happy with my or his coming into their emergency department, I am not going to flash a piece of paper to them saying I can still come until the end of July. That is the reason we do not have contracts.

Other hospitals would prefer to have contracts with us, in which case we have provided them contracts. We do not charge for the service. We do not charge the family doctor for the service. We do not charge the hospital for

the service. In fact, as it turns out in the overall concept of billing to OHIP, it is cheaper for them to have Geoff and me work in Cobourg than to have the local guys because we have to bill differently. We bill under a different system that is a cheaper system than the local people.

The Chairman: That is very interesting. Are you the only one doing this?

Dr Zacharias: There are a number of people who do it, not in an organized fashion, where a group of three or four guys might cover a small community hospital, but we are the largest group of independent physicians in this province at this present time.

The Chairman: Thank you for coming before the committee and giving us your perspective on this bill.

Dr Zacharias: Thank you for the opportunity.

The committee recessed at 1138.



CAZON  
XC12  
-578

STANDING COMMITTEE ON SOCIAL DEVELOPMENT  
INDEPENDENT HEALTH FACILITIES ACT, 1989  
TUESDAY 15 AUGUST 1989  
Afternoon Sitting





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)  
VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)  
Allen, Richard (Hamilton West NDP)  
Beer, Charles (York North L)  
Carrothers, Douglas A. (Oakville South L)  
Cunningham, Dianne E. (London North PC)  
Daigeler, Hans (Nepean L)  
Jackson, Cameron (Burlington South PC)  
Johnston, Richard F. (Scarborough West NDP)  
Owen, Bruce (Simcoe Centre L)  
Poole, Dianne (Eglinton L)

Substitutions:

Dietsch, Michael M. (St. Catharines-Brock L) for Mr Daigeler  
Hosek, Chaviva (Oakwood L) for Mr Beer  
McGuigan, James F. (Essex-Kent L) for Mrs O'Neill  
Reville, David (Riverdale NDP) for Mr Allen  
Smith, E. Joan (London South L) for Ms Poole

Clerk: Decker, Todd

Staff:

Drummond, Alison, Research Officer, Legislative Research Service

Witnesses:

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriole L)  
Sharpe, Gilbert, Director, Legal Services Branch  
MacMillan, Dr Robert, Executive Director, Health Insurance Division

From the Ontario Women's Action Coalition:

Maher, Janet

Individual Presentations:

Bateman, Dr James Ennis

Fullerton, Jack

From the Toronto Psychoanalytic Society:

Szmuilowicz, Dr Julio  
Graham, Dr Ian  
Kindler, Dr Alan  
Wright, Dr Martha

From the Board of Directors of Chiropractic:

Stolarski, Dr Stanislaw, Registrar  
Charette, Gerard, Legal Counsel  
MacLeod, Norman, Consultant

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 15 August 1989

The committee resumed at 1413 in committee room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: The meeting of the committee will come to order. The standing committee on social development is convened to hear information with respect to Bill 147, An Act respecting Independent Health Facilities. This afternoon we are pleased to welcome as part of the audience a class of students taking a course with the Civil Service Commission on dealing with the government environment. Welcome to the committee.

Mr Reville: The debriefing will be horrible.

Hon Mrs Caplan: I knew you could not resist.

The Chairman: Our first delegation is the Ontario Women's Action Coalition, with Janet Maher, interim co-ordinator. Would you take a seat there, please? Welcome to the committee. You have half an hour of time. You may divide that time as you see fit between presentation and questions. Committee members usually appreciate it when you leave some of that time for questions.

ONTARIO WOMEN'S ACTION COALITION

Ms Maher: Thank you. I would like to leave as much time as possible for questions because I think the kind of presentation I want to make, since a number of our member groups will also be making presentations in the next week or two, is to talk in a general sense about a couple of broad issues and a couple of very specific issues. I hope you have a chance to look at the written brief as time goes on.

I guess one of the things we want to say is that we are pleased to note the increasing frequency of references in advisory reports and various studies published by the ministry and by other bodies here in the Ontario government that make reference to preventive and public health initiatives and talk about the community base for health and other social services.

At the same time, though, I think we are quite disappointed with Bill 147 to the extent that although it seems to be set in those contexts, we are not so sure that in fact it is a community-based initiative, nor that the regulations and the licensing provisions are necessarily going to provide for real community-based health care. So we make a number of recommendations, and I will go through those in a few moments.

Basically, what I want to say is that the brief begins by commenting on two main areas where we think there are real inconsistencies in the design of our contemporary health care delivery system in Ontario. The first is the

extent to which, and I do not think this should be a surprise to anybody, hospitals, clinics and other health facilities, institutional health facilities including the proposed independent health facilities, can be characterized as a system of sickness control rather than a system for health care and the promotion of health care. The second issue, as I have indicated, is that we have some concerns around the procedures for ensuring and enhancing community responsiveness and accountability in the delivery of health services.

Finally, I would sort of indicate that we want to raise some questions around what has been referred to as the grandfathering of facilities as of 2 June 1988 and a number of questions around the regulation of health care professionals who are not necessarily currently governed by the College of Physicians and Surgeons of Ontario.

Basically, the context I want to set for this is that we think the availability of reliable facilities and equipment, adequate supplies and qualified health care practitioners is important in the restoration of good health for the general population. I do not think there is any particular argument on the fact that access to state-of-the-art technology has prolonged the lives of many who would not have survived even as recently as a decade or so ago, but we have some concerns whether those items should be the main focus of a system of health care.

When we consider health care for women, we think the internal contradictions are even more apparent. The single most frequent reason for which women in Canada are hospitalized relates to pregnancy, which is not an illness although it may occasionally be accompanied by illness of one sort or another. It is questionable, moreover, whether medicalization and artificial regulation of many other aspects of the reproductive processes produce any better results than time alone or aggressive health promotion.

In any event, I think we are concerned that when the question arises of the best use of our resources and the overall maintenance of health, the evidence is mounting that longevity and quality of life are more profoundly affected by a whole array of issues quite removed from hospitals and clinics and the people who make them run.

These include not only genetic predispositions to particular complaints, but social factors such as lifestyle, quality of work, quality of family life, the kind of shelter and the state of the environment. Although I think we see that it is important to allocate a portion of our resources to restoring and maintaining the health of those subject to various ailments, we want to see new initiatives moving to the more logical objectives of maintaining wellness and preventing illness.

Indeed, we think it is important that relocating many of the routine health and medical procedures out of the hospitals to community-based facilities would have a number of advantages beyond what we assume has been the government's primary motivation in curbing health care spending in proposing Bill 147. In short, we think community-based facilities have the potential to demystify sickness control for nonmainstream citizens whose cultures might lead them to disrupt the role of institutional health facilities in health care and health promotion.

Research evidence from Quebec, the United States and elsewhere suggests that local health care facilities organized in the context of particular cultures and communities are likely to be more effective vehicles for aggressive health promotion and illness prevention for women and children as

well as for men. It is in that broader context that we think the Independent Health Facilities Act needs to be based.

I guess the first problem I think we want to identify is that although there is reference to "community" and "community-based," nowhere in the act do we find a clear kind of commitment to a community-based facility, nor in our view is the legislation going to require that facilities be community-based in the sense of having a community board, having community bodies responsible for advising and deciding on the allocation, the establishment, the regime that might go on in those facilities.

#### 1420

So far as possible application, licensing and funding arrangements have been set out in the bill or discussed, as we understand it, at earlier stages of the legislative process, the coalition fears there will likely be little motivation in fact for a community-based group to attempt to organize an independent health facility. The process for deciding on the need for particular services in particular areas is at the discretion of the director and ultimately the minister, and of not the community, which we think it should be serving, were a community-based group to be licensed. Moreover, there is little assurance that it would necessarily be in a position to finance such a facility, again, except at the discretion of the minister.

It is our view that without a clear commitment to community responsibility and accountability in the bill, the bill will end up being a strategy for privatization in the hands of independent operators of some of the more profitable components of the health care system which has been financed essentially as a public utility for the past 30 years.

Given the history of medicalization of women's health care, particularly of women's reproductive health, the coalition is concerned about the discretion retained by the minister in licensing and financing facilities. While we understand that existing free-standing abortion clinics have provided one of the models envisaged in Bill 147, there is no assurance that those clinics, birth centre services or more comprehensive reproductive health care and health promotion services would not be completely prohibited once the new legislation is in place.

A further concern relates to the recommendation in section 6 of a preference for nonprofit facilities operated or under the control of Canadians or landed immigrants. Were the government genuinely committed to community-based health care, the coalition believes the section should require, rather than prefer, such operators and support that commitment with a funding mechanism that would ensure effective and efficient community clinics.

We have a couple of special concerns. Beyond the general and more philosophical issues raised above, our coalition has a number of specific concerns about ways in which the implementation of Bill 147 could result in a deterioration of resources available, particularly in the areas of women's reproductive and mental health.

First, while we understand the impetus of section 7 of the proposed bill in providing for a transition period for the licensing of existing facilities, we do have some concerns about the proposed mechanism of grandfathering, which would give a year's grace to all facilities in operation as of 2 June 1988, but would require, as we understand it, immediate closure of any facilities opened since that time, for instance, the Women's Choice Health Clinic on



Parliament Street, and would prohibit the opening of other facilities, for example, the Toronto birth centre, which has already invested considerable energy and resources to develop a proposal with broad community support.

In the absence of current and public estimation of the need and cost-effectiveness of independent health facilities, which we believe should precede the implementation of any legislation such as this, any transitional date is necessarily arbitrary. Given the delay since first reading of the bill, it is our view that the arbitrary grandfathering date should be revised, if the bill is passed, to the date of third reading or even the date of proclamation.

Second, and consistent with our more general concerns about the medicalization of health care in Ontario, we continue to be concerned about the potential of the section 24 provisions to reinforce a medical model focusing on control of sickness rather than on promotion of health. The implied regulation by components of the College of Physicians and Surgeons of Ontario presumes either that facilities will be operated by physicians or at their discretion and direction, and that any standards to be applied in the licensing and evaluation of facilities will meet with the approval of that college and not necessarily the other colleges.

Combined with the considerable discretion left in the hands of the minister and the lack of an independent appeal procedure, such provisions, we believe, have potentially adverse implications for all other health disciplines and for the autonomy of their respective governing and standards bodies. It is our view that the enactment of Bill 147 would make much more sense if its proposal were the end product of an extensive evaluation of health needs and resources, rather than what often appears to be one more try at reducing the mounting costs of health care in the province.

A related concern, as I indicated, is that the Bill 147 provisions for inspection and assessment seem much less stringent than, for example, the quality assurance and accreditation procedures currently required of public hospitals. To the extent that the proposed independent health facilities have been promoted as promising more efficacious implementation of high-technology procedures and new procedures than the public hospitals, we think it is quite important that adequate evaluation and testing protocols be in place for those procedures and be an integral part of the licensing process.

Our recommendations, in view of that discussion, are that we are suggesting a tabling of Bill 147, pending, first, a province-wide review of health care needs and resources, including an evaluation of the efficacy of relocating particular medical procedures from the existing institutional settings to independent facilities, and the completion of the health professions legislation review and related legislation, and a clarification on the most effective division of labour among health care professionals in community-based facilities.

Second, we would like to see provision to ensure effective community-accountable facilities through the use and support of existing district health councils, community health centres, boards of health, public health units and other community-based health organizations in establishing the need in developing strategies for the independent facilities.

Third, we think it is important to implement a funding mechanism to ensure that community-based facilities can offer equal access to comprehensive

services and health care education consistent with the principles of the Canada Health Act.

Fourth, we think it is important to amend section 7 of the bill to require, rather than prefer, Canadian nonprofit operators.

The Chairman: Thank you for your presentation and for leaving some time for questions from committee members. We will begin with Mr Reville. We have about 17 minutes.

Mr Reville: Ms Maher, I enjoyed your presentation and I agree with your philosophical thrust. Do you have any advice for us, given that my view would be that operations like the Toronto birth centre, which in spite of much effort is still not established, and the Women's Choice Health Clinic, which is operating, will not be cut by the grandfathering provisions? You have recommended that we grandfather to third reading or proclamation. Are you concerned at all that might grandfather operations you might not approve of?

Ms Maher: I have some concern in that way. I guess the kind of corollary provision that is important is to talk more about the licensing and evaluation procedures. I find it difficult to conceive that whoever gets grandfathered in is there simply because they were there first and not because the strategy that is implicit in the clinic or in the centre that is being set up happens to be the best thing to answer the health needs of the people in the community.

Mr Reville: I do not believe the government strategy is to grant licences to operations without going through that kind of review. What they are saying is that if you have been operating, you will not immediately be put in jail. I am being a bit hyperbolic in that case. But you still have to go through the exercise of getting a licence. There is a lot of nodding going on here.

Most of the operations out there, I suspect, are surgical procedures that have come to be performed outside of hospitals. They are not the kind of thing you are interested in, which is community-based stuff. The dilemma for me, and I wonder what your advice is on that, is that absent in the bill are the kinds of principles you are interested in in terms of community control, community accountability and community responsibility. The Minister of Health has indicated she is not interested in adding those principles to the bill, which I think is a shame. If we were to ask your advice on how to do that, could you come up with some suggestions?

Ms Maher: I think there are a number of bodies already existing, the local health councils, boards of health, that individuals might be drawn from, and I guess the models of community health and social services in the community health centres, for instance. Personally, I am a bit more familiar with the social service area. There are plenty of very good models for having bodies set up where you can combine expertise and interest in a community that would be quite helpful; I do not think anything other than community boards of health, practically speaking.

1430

Mr Reville: Would you like to see that in the legislation, some description of that kind of accountability mechanism?

Ms Maher: Our general concern is that, yes, we think it is important

that those kinds of community accountability are specifically within the legislation. Our reading of the proposed bill, and even the one with the amendments that came out over the summer, is still that it essentially can be a strategy for privatizing some of the most profitable pieces of the health care system, leaving us as citizens, health consumers and, particularly if you are talking about the consumption of medical services, public hospitals in a position of continuing to have to provide services that may not be as profitable as some of the ones that could be offered in independent health facilities, and they could be taken completely out of our hands.

Mr Reville: You do not see anything in the bill that gives you comfort that this instrument in itself does anything to demedicalize Ontario.

Ms Maher: No.

Mr McGuigan: I am not a regular member of this committee, so I do not have the background in the matter at hand, but you mentioned something that has always puzzled me; you say that nowhere in this bill or in broader Ministry of Health policy is there a clear commitment to health care and health promotion responsive and accountable to local communities. This is often a criticism we hear in the House and from people who criticize the whole Ontario health insurance plan program, that it is not directed towards prevention. I just want your response to my view of the OHIP program, that it is very much preventive and that people never have to consider whether or not they can afford to consult a doctor.

You often hear the criticism that a person goes in for a cold, he gets some tablets and the doctor tells him to come back again. They criticize that system. In my view it is a pretty good system in that those people get the attention they require. It is oriented to prevention as much as it is to remedial action, as opposed to the US system. I have not been in a US doctor's office for years, but I am told that the people in the US doctor's office are sick, and they are sick because they often neglect to come to the doctor because of financial considerations. I am just wondering if you would make some comments about the whole system in relation to my comments.

Ms Maher: Sure. I may be lucky to have been a child when OHIP and the Ontario Hospital Services Commission were introduced, but I do remember members of my family talking about the time when OHIP was not available and when it did cost incredible amounts of money to get medical care.

I think, though, we have had 30 years of that. I am not advocating moving towards an American system. I do not particularly want to talk about a quantitatively new area, that simply keeping colds or childhood or adult diseases under control for whatever reason is not necessarily the point. We need to be thinking in a broader sense of spending money on having healthy ways of life, which we do not necessarily spend money on.

Even the Premier's Council on Health Strategy that reported in the spring talked for the first time about actually putting one per cent of health expenditures into a preventive program. I think that is an incredibly important initiative, but I do not know when it is going to happen. One per cent does not seem to be very much, although probably given the size of the health budget, it is quite a handy sum.

Mr McGuigan: The point that has always bothered me in that approach, and I am just asking for your advice, is how I, as a consumer, go about preventing ill effects to my health, other than what I am doing now. I do not



smoke and I drink in very modest amounts, I go to sleep at night and so on. How do I go to a doctor or to a doctor care system or health care system and get some sort of prevention that is going to prolong my life? I wonder about the practicality of all this. I hear people talking about it constantly, but when it comes to my level, I am in the dark on how to go about doing this.

Ms Maher: Again, I have some concern about a doctor-centred system, and I think you talked about something very close to that. There are a number of things you probably do, like stop smoking. If you got that advice from a physician, I am glad to hear that.

Mr McGuigan: I did not start in the first place, in my case.

Ms Maher: But there are components of health education which are obviously rubbing off. I do not think they are rubbing off on enough people, and one of the things I think we need to do is spend money on making more people get the message you got that resulted in your not starting to smoke.

Mr Carrothers: I was just curious. In your recommendation 1, you have linked dealing with this bill with completion of the health professions legislation review. Perhaps you could expand a little, as it is not quite clear to me why those two should be so inexorably linked.

Ms Maher: The main concern we have is that as we understand the bill as it is currently written, it looks like the facility would have to be set up essentially at the direction or on the instructions of a physician, so it would be a physician-based model. One of the kinds of concerns we have is that there are a number of other health disciplines or health professions, health care professionals, who operate and who I think provide some quite good levels of both preventive and acute care. Our reading of section 24 of Bill 147 indicates that all of the professions would have to report to the College of Physicians and Surgeons of Ontario.

Mr Carrothers: Perhaps this is where you may not be completely up, because when you say it has to be physician-based, that is not how I read it necessarily, although obviously many of the existing examples—I guess one of the reasons I would like to see this dealt with, and perhaps we could get some comment, is that there are existing examples we should get in operation. Section 24 is being amended and I think perhaps the college—

The Chairman: I think it would be useful—You may not be aware of another amendment.

Dr MacMillan: There are just a couple of comments, some of them having been made before.

The first is that the services that constitute a facility fee are, of course, insured services. Insured services are primarily rendered by physicians, but this will provide a funding mechanism whereby allied health care workers and others involved in health care delivery will be able to have a source of funding. While primarily physicians have been limited to the OHIP schedule of benefits, this now opens up the ability to expand certain services, such as a birthing centre, which you have already mentioned in your document, to provide the supportive overhead costs that would be needed in that expanded type of service that OHIP is limited by legislation from providing.

As far as the issue of the registrar is concerned, we have an amendment



before the committee that addresses that issue and will allow for "registrant," by virtue of that, to mean the chief executive officer of the appropriate licensing body. If a nurse in such a clinic was under suspicion and needed to be evaluated, it would be the college of nurses that would be called in.

Hon Mrs Caplan: The other is a corporate entity. There was some suggestion that only physicians could operate. The corporate structure that is contemplated is that in fact any corporate structure, community group, individual, not necessarily a physician, could apply under the request for proposal and that would be considered. So it is not necessarily only owned and operated by physicians.

1440

Mr Carrothers: I do not know if that changes your view at all.

Ms Maher: I am reassured to hear that. I still would like to see what happens when specific applications are being reviewed, because I still suspect that there is going to be a preference for physician-operated centres as opposed to any other kinds.

Hon Mrs Caplan: What section is it in the new legislation that has the preference, which says Canadian nonprofit will be given preference? Subsection 6(3) on page 6 of the bill very clearly states a preference for Canadian nonprofit.

The Chairman: I think we should move to another questioner.

Mr Jackson: Prior to today I raised with this committee the concerns that found their way into your recommendations, and I want to thank you for that. I thought perhaps I was the only one who was concerned about the fact that this is one of three pieces of health care reforms which are under active consideration by the government. Although the principles enunciated in this bill can be applauded, embraced and worked with, where we get a breakdown is that it seems to be out of sync with where the other elements of reform tie in. I am pleased that you have provided such clarity on that.

I am concerned about the issue of the completion of the health professions legislation review because of the division-of-labour issue, and you have hit it right on the head. Those who examine hospitals know of the imbalance in terms of nursing staff, where the cuts occur first. It is very much a gender-in-health-care issue, and that is really what your subsequent concerns have just recently enunciated.

I also have a concern which you have not put as fine a point on, where you talk about recommendation 2, effective community accountable facilities. Are you aware of some of the discussion papers with respect to the envelope system and the district health councils? Is that closer to what your concern was?

Ms Maher: The model I had in mind and that the people who worked on the preparation of the brief had in mind was the centre local de services communautaires in Quebec. As I say, I do not know specifically the current discussion papers you are referring to, but that was our reference point.

Mr Jackson: Essentially, it deals with the concept that potentially we could strengthen the role of the district health council. We would have to ensure that its representation was sensitive to all elements of the community,

which district health councils seem not necessarily to be at this point; that is why there is a discussion paper.

Second, potentially the government, with its umbrella cap on health care funding at 33 per cent, a third of Ontario's budget—That is it, we are not spending any more on that; that is a political statement of the government and therefore where does it manifest itself? If the district health councils are responsible in some sort of envelope system, then you can call it whatever you want, it amounts to the same thing.

Now you get into where this legislation, Bill 147, fits into a schematic or an administrative plan for health care in this province where people in the local areas in district health councils are deciding how much service is provided and to whom? Albeit done more efficiently and less expensively, but access points will be adjusted if there is only so much money to apply that. Is that an area of concern you have with respect to this legislation coming in advance of any real clarity on how the DHCs will model themselves in terms of implementing and licensing under Bill 147?

Ms Maher: I would say not only there, but I think there might be concerns afterwards as well. I am not personally sure. It is not a question we have dealt with a great deal in the coalition, but whether 33 per cent and the capping necessarily—If we want higher quality health care, we might want to be moving that 33 to another number.

The Chairman: We are running out of time, Mr Jackson. I have one more questioner.

Mr Jackson: I know we are. One more very briefly; it has to do with your reference to the funding mechanism. No one is talking about transition funding as opposed to—I tend to hope we will discuss it in that vein, because when you downsize a corporation or any other activity in government, there is an increase in costs in order to downsize. But it begs the question: With regard to all the equipment an abortion clinic might use, for example, which is currently in a hospital and which they are going to move into a clinic, who owns that property? Who owns that equipment and how would that be made available?

It becomes redundant equipment in a hospital if we are going to put it now into a clinic. Nowhere do I get a sense as to how we make the transition with what could amount to very expensive equipment for eye operations and so on; lithotripsy is probably the most expensive example. Do you have any comment on who owns this equipment and how that would be made available in terms of transition funding to get clinics started?

Ms Maher: That is essentially why we were quite strong on the point of nonprofits, because our understanding is that wherever this stuff ended up, even if it were purchased separately by someone who was going to set up a separate facility, somehow consumers would end up paying for it.

Mr Jackson: A second time, because they already have the equipment. Thank you, Mr Chairman. I appreciate your indulgence.

The Chairman: Mrs Smith, quickly with your question.

Mrs E. J. Smith: You come from Toronto, or your group may be scattered across the province; I do not know. I come from outside of Toronto and I have served on a health council there. It seems to me that we are

talking about quality control of delivery of service, but also talking about community groups, getting out to the community.

A lot of what is intended in this bill is to move out of hospitals, which become more and more centralized. Therefore, the smaller communities, by putting forward propositions, may in fact where there is enough volume be able to draw the services out closer to them. I see this as making it more community related, whether the proposal comes from some country doctors or whether it comes from a community group or whatever. It gets it away from your big centre concept.

Do you not have that sense of it at all, that this is breaking down from big hospitals to more local groups, rather than—

Ms Maher: I think there is a possibility for that. Concerns that have been represented to us by our members, for instance, in places like Barrie and Parry Sound, smaller towns that would not necessarily be big enough to have more than one or two of these facilities—

Mrs E. J. Smith: But that would be better than none.

Ms Maher: —are that they would continue to be primarily medically centred, rather than, for instance, providing specialized reproductive health and mental health kinds of strategies through other kinds of professionals, whether psychologists, nurses, nurse practitioners, midwives and so on and so forth.

Mrs E. J. Smith: I guess it is partly how we use the bill that will be the issue rather than the bill itself—

Ms Maher: You are right.

Mrs E. J. Smith: —because having heard the minister's statement in the House on birthing clinics, which would fall under this bill, my understanding is that they would make great use of all preventive things, educational tools and so on, along with giving birth, and that they could be kind of spread around. It is the use of the bill, I think.

Ms Maher: You are right.

Mrs E. J. Smith: Thank you.

The Chairman: Thank you very much for taking the time to make your presentation and share with us your views on this bill.

Ms Maher: Thank you.

The Chairman: Our next presentation is by Dr James Bateman. Dr Bateman, would you take a seat? Do you require some assistance with your audio-visual? Would you mind being seated? the microphone would pick you up better if you were seated.

Dr Bateman: I can see a little better that way; that is all.

The Chairman: Okay.



## JAMES BATEMAN

Dr Bateman: The opportunity to talk to this committee is very much appreciated. The purpose of this presentation is to call attention to the contribution that ambulatory surgical units can make to the overall health savings picture.

Ideally, these units should be housed in doctors' office complexes and exist as completely independent units in the community. In the present context, I am suggesting that these units be established, staffed, financed, equipped and operated by a co-operative group of physicians.

1450

There are a number of aspects of this project which I can best outline by referring to the screen if we could have the slides. First, I would like to say something about the rationale of outpatient surgical units. I am sure most of you are familiar with the Canadian task force study which some time ago singled out hospitals as the prime spenders in the health care field. The outpatient ambulatory surgical principle attacks a major health drain. This has been made possible by the new techniques, the new tools and the new anaesthetics which are in the field now. One of the advantages is that the units afford quick access to these advances and that prompt decision-making is feasible in organizing the new equipment.

When it is directly under professional supervision, there is maximum use of the equipment and it is suggested that this be provided by the unit, without capital cost to the ministry. There are a good number of trial units which have been very successful in the United States and there are some small units in this city which have worked satisfactorily so that the application of these on an enlarged scale is past the experimental stage. There has been broad public acceptance of this trend. The walkout principle appeals to patients. The abbreviated total time loss is important to the wage earner in several aspects and it unearths savings not previously available.

The far greater access provided to patients by these units in the community is significant. As we are thinking about the trend towards community care, it encourages community care. It discourages the use of expensive element in our care, pre- and post-operatively, apart from the actual surgery, and affords a new and direct control of certain health costs.

The units unearth savings not previously available and the abbreviated time loss is of special advantage to the wage earner, not only with reference to his hospitalization but also with the quickness with which he obtains recovery.

It probably is possible to transfer as much as 50 per cent of the surgery which is done now into such units. The question has always been whether the savings that are available could be salvaged or harvested, but as studies have gone along, it has become apparent that the provider can reach 70 per cent of the savings involved.

In summary, the surgical advances are triggering a new method of surgery in front of our eyes. The captive-care principles of hospitals are no longer as strongly operative. The safety of the public has been demonstrated by this method and the patients welcome this transformation. There are major economies feasible and this potential sparks other economies and serves as a good example. There are special benefits to the young and the elderly. It comes



perhaps as something of a surprise to learn that before the last war about 70 per cent of children's surgery was done on an outpatient basis. Children respond well to this environment. The principles sparked increased application of new techniques.

The location of these units requires some attention. The best place for them to be is in doctors' office complexes so that traffic away from the hospital to the community is encouraged. Studies have shown that there is an increased operative infection rate in hospitals that house these units. Hospital units, of course, can be successful but they need to be established as separate buildings.

The use of these units provides a marked saving in capital costs, as suggested here, and there is quick availability, avoiding administrative delays. The independent units spark increased accessibility on the part of the patient. The units, being in the community, keep the patient closer to the practitioner, so practitioner collaboration is increased. The most important man in medicine today is still the general practitioner.

The off-the-street traffic in major hospitals is a menace and it is removed by having these as separate units. Of course, they can be provided much more economically because duplication in hospitals is a costly manoeuvre.

The advantages of independent units include providing savings in decreased hospital volume; that is, there are fewer patients admitted to active treatment hospitals. There is a degree of capital cost removed from the ministry. The operational and capital interest are diminished and there is a degree of capital contributed to the health care system. This provides to the ministry control of the certain expenses not previously available.

Another advantage of independent units is the superior use of costly equipment and it avoids individual hospital restrictions. Let me quote an example that is rampant, at the present, in our business. The use of magnetic resonance imagers, which is a very significant advance in all forms of diagnosis, does not need to be incorporated in every hospital but it is difficult for St Michael's Hospital to use the unit if it is in Wellesley Hospital, whereas if the unit was in a separate unit on University Avenue there would be no problem about patients coming from all the hospitals in the area to use this expensive piece of apparatus.

#### 1500

In summary, the advantages of independent units: It enhances community medicine and superior traffic control of infection, there is marked capital savings by using community office facilities, the illness episodes are more cleanly defined and the recordkeeping can be improved, the service profiles of patients are more accurately defined and more available, there is improved patient accessibility to medicine, the automatic patient relationship to the doctor's office, with attendant diagnostic economies, is enhanced by these units, it fosters the use of community aids rather than aids from the hospital.

We might say that the advantages of independent units can be summed up in a corner store principle which, in this instance, can provide quality medicine at bargain rates.

The Chairman: Thank you very much for your presentation. We allotted 15 minutes for your presentation and you have used almost all of that. I am saying that for the benefit of the members of the committee. We will take

perhaps three quick questions, one from each party. Then we will have to move on to another presentation.

Mr Jackson: You have had a chance to examine the legislation. You are familiar with the details of this legislation, Bill 147?

Dr Bateman: Yes.

Mr Jackson: In a little more detail than just the general issue of independent health facilities?

Dr Bateman: Well, the ambulatory surgical units would probably just form one facet of Bill 147. There are certain communities that would benefit by an ambulatory surgical unit on an independent basis and in another community the independent unit might need to be somewhat different. Perhaps it would be an arthritic unit that had to be in the community.

Mr Jackson: Let me ask you this question: I understood your presentation. You used the magnetic imaging as an example of a piece of expensive medical equipment taken from a hospital setting and put into a clinic setting. My understanding is that most hospitals would conduct fund-raising, through their foundations, to raise the necessary money, so that a major element of the cost of health care in this province is also done through public prescription or through fund-raising. Do you foresee an independent health facility, for example, with a charitable licence, undertaking fund-raising to help reduce its overhead costs?

Dr Bateman: That is a very prominent possibility. This has happened many times in the United States. One of the classic examples is in Sarasota. They have a beautiful day care unit, across the street from the major general hospital, which was funded by a philanthropic individual and subsequently elaborated and developed by the staff. There are all types of possibilities like that.

Mr Jackson: I have no further questions there, but perhaps we can get the minister to respond at some point to that whole concept of the access to charitable numbers, the ability for a group under contract charging a facility fee to the government being able to increase its profitability or reduce its costing through public prescription and subscription of sponsorship and fund-raising and getting tax receipts for that. Will that be eliminated to this whole group?

The Chairman: Could he take that under advisement?

Mr Jackson: Okay.

The Chairman: Mr Reville is next.

Mr Reville: I do not have any questions. I just want to thank you very much for an excellent presentation and a brief slide show. You did a lot of work.

The Chairman: Dr Bateman, would you wait please? We have more one question.

Mr McGuigan: You give an example which I think touches on one of the hearts of our medical problem. That was the case of taking a patient from hospital A to hospital B for the use of special equipment such as the magnetic

imaging equipment. You said there were difficulties with that; I do not know, you used the word "impossibility." Are the difficulties medical or physical, or are the difficulties in the political sense in that you have rivalry between the hospitals?

Dr Bateman: The concept of the independent unit is based on the day care principle. It is anticipated that the upkeep would be provided on the basis of a rate of one day per diem to the unit, with the per diem rate gauged to the per diem rate of the group of hospitals in the area in which it is developed. It is felt that if the government supports it in that fashion, which I believe has been suggested as a possibility, if it is properly managed and the unit is operated satisfactorily, the capital costs can be serviced from that income.

The professional fees, of course, are a separate entity. There is no change in that. The staff submit their bills just as they do now from hospitals, and the staff abides by the regulations, tariffs and so on that are already established. It is not possible to predict in the future what technological developments will come along and be costly. There might have to be some adjustment with reference to that, but there will likely be a concomitant improvement and savings on what that new tool does, as far as hospital occupancy is concerned. It is a closed circuit.

Mr McGuigan: I still have not gotten to the point. I think you said it was not desirable to have that unit, say, in one of a number of hospitals and the patients come from the outlying hospitals to the, say, central hospital. It was more preferable to have that as a separate unit away from a hospital. That was the point I was trying to clarify.

Dr Bateman: One of the hidden benefits has to do with the sophisticated diagnosis which is part of our armamentarium. There are a great many procedures carried out in hospitals that have been done just by habit. Things such as myelograms, discograms and so on; they are all done in hospital and they can be done on an outpatient basis. But we have not had the facilities to do that. There have not been enough corner stores to attract the patients to make that contribution, to make that saving.

The Chairman: Thank you very much for your presentation. That concludes your presentation and we appreciate the time you took to come down here.

Our next presentation is by Jack Fullerton. While he is coming up, we would like to thank the class with the Civil Service Commission. Thank you for coming, Professor.

1510

Hon Mrs Caplan: The answer to Mr Jackson's question—

The Chairman: Would you like to proceed with it now? Okay, go ahead.

Hon Mrs Caplan: There would be nothing to preclude a nonprofit organization which has a charitable number from responding to a request for proposal as long as it acknowledged its obligations to meet the requirements of the charities legislation and the Income Tax Act, which are very specific in what charities can and cannot do. They would not be precluded from being able to reply to a request for proposal.



Mr Jackson: Currently for hospitals there is a separate piece of legislation covering foundations enabling them—

Hon Mrs Caplan: You asked about charities, the charitable numbers. The answer is very clearly that under the act anyone, including a hospital which—

Mr Jackson: That is not the answer. I would ask you to research the question because I asked you to transfer—just take the example of buying a lithotripter or a computerized axial tomography scanner. My hospital, through its foundation, raised additional money to make up the shortfall to buy the CAT scanner. Now we are suggesting—and the presentation was very well put—taking that expensive piece of equipment and letting the clinic acquire it. What has potentially evaporated is the possibility to go out and solicit funds in the same fashion or a fashion similar to that which a hospital foundation does. I am simply asking if that option will be denied. Until we get the legal input on that question and get a detailed answer about it—your narrow response was, and I could have given the answer, that if you comply with the legislation you can do it.

Hon Mrs Caplan: No, there is nothing in the—

The Chairman: Minister, just a minute. I think this is going to lead into a different—

Mr Jackson: That is why I put them under advisement.

The Chairman: I think at the end of the day, when we have heard the delegations, perhaps we can get into it a bit.

Mr Jackson: Mr Chairman, is it impossible, with all this wealth of staff, that we cannot get written responses to these tabled questions?

Dr MacMillan: What wealth of staff?

Mr Jackson: I see three behind you, and this morning we had two additional legal staff. On opening day we had, I was told, as many as four specific legal staff, even from the private sector.

The Chairman: My concern as chairman is that we have delegations scheduled. They may have other appointments, and I want to keep as close to the schedule as possible.

Mr Jackson: This is simply a procedural question.

The Chairman: Let's get back to the issue Mr Jackson raised when we are done hearing all our delegations today.

The Chairman: Mr Fullerton, welcome to the committee. We have allotted you 15 minutes. We would appreciate if you would leave a little bit of that time for questions from committee members.

Mr Fullerton: I will try, Mr Chairman, as long as some of my time does not come off Mr Jackson's time. He did not take any of my time.

The Chairman: No, you are starting now.

Mr Fullerton: I might point out also it is very warm in Windsor, and



the first health facility I have in my car is 60-miles-an-hour air-conditioning. If you are going to have an independent health facility, the first one might handle chilblains.

The Chairman: We as committee members can relate to that comment, so you have got us all on your side now.

JACK FULLERTON

Mr Fullerton: I do not come with any great credentials in medicine or indeed in planning, health or otherwise. I come armed only with the credentials of a citizen who has lived and prospered in this rich province and I come with credentials of a journalist in my community who has reported on the growth and development of that community on a weekly basis.

It is a truth that people accept the good actions of government without comment and all too often without accolades. It is also a truth that people ignore pre-announced actions of government until after the fact and legislation impacts directly upon them. Every journalist knows what makes a good news story. Every reportable story has at least one of the following elements: it has conflict, affects the reader's life, affects his lifestyle or affects his pocketbook. That is why war makes good news.

Sometimes it is difficult to make the reader comprehend that an event is going to have an effect upon him or her. The effect may be immediate or it may be in the future. A future effect is often hard for the reader to perceive. That is why Cassandra was ignored, the prophets were stoned and messengers are shot. That is my prologue. Now I would like to take a look at the legislation.

This bill deals with medical services, and I confess I found it had some symptoms of medical illness in itself. In some cases, it revealed signs of schizophrenia, in some areas paranoia and in yet others a tendency of induced paralysis. My concerns, as set out more explicitly in my brief, are in three areas: (1) the lack of preciseness and direction as to exactly where in the locality independent health facilities may be established, (2) the perceived impreciseness with its resultant conflict of decision-making in certain portions of the bill and (3) creation of yet more quasi-judicial bodies with no direct legislative responsibility.

Concerning the location of IHFs, sections 2 and 3 of the bill attempt to set out the type of facility that is being contemplated and where such a facility may be established. The problem is that most municipalities in their official plans and subsequent zoning bylaws have not contemplated the establishment of the type of facility proposed in this legislation. My research indicates that most zoning bylaws cover medical clinics and doctors' offices. In Sarnia, which is my home town, a clinic or a doctor's office may be established in a residential zone. In a community commercial C-2 zone anywhere there is a Mac's Milk you could have a clinic. A medical clinic may also be established in a mall or plaza.

What I am asking you to perceive, in light of the controversy presently surrounding the abortion question and which, in future, may well surround other aspects of life creation, are situations which may result as contending forces on such questions demonstrate to emphasize their arguments. Unless action is taken now, and it can be taken within the provisions of this bill, the facilities here envisioned may well proliferate throughout a community and the cost of such things as policing and zoning hearings will grow to unconscionable amounts. If facilities involved in such practices are to be

established under the provisions of this bill, and I believe that if and when Parliament acts such establishments may gain unquestionable legal, but I do not believe ever moral, status, then such would be the case.

It were better then that such facilities be located within a specifically zoned area of the areas within the locality. This bill can ensure such an end. I have proposed that clause 5(3)(b) be amended by adding the words "the location within" before the words "the locality in which." I am taking location to be specific and locality to be general. An independent health facility may be proposed for the locality of metropolitan Sarnia. Its exact location would be determined by reference to zoning bylaws covering such facilities. Acceptance of this amendment would be a signal to municipalities to initiate planning action now, which would provide for local debating and results of which would remove a potential blocking or delaying action in the future when the minister elects to establish an IHF in a locality.

My second concern is in the use of what I believe to be imprecise language in the bill. The explanatory note indicates that the minister proposes and the appointed director disposes. It is when these lines of authority are blurred the confusion arises. In section 17 it is noticed that the director administrates, but sections 9, 9a and 18 provide the minister with overriding powers. The old army adage has it, "Order, counter order, result: disorder." If the minister has ultimate authority and ultimate responsibility, why not provide for such right in the beginning and show consistency throughout the bill?

You will note that section 24 implies that reports are made to the director by inspectors appointed by the minister. If appointees owe their appointment to someone other than the superior to whom they report, then there is the very real potential for divided loyalties. We all know that one cannot serve two masters.

The matter of divided loyalties is further compounded when the bill deals with the appointment of assessors. You are all familiar with the concerns that arise when the public perception is that professionals policing themselves protect themselves. "Quis custodiet ipsos custodas?" is a well-known adage that warns against such practice being enshrined in this bill.

Section 25 purports to make it clear that the assessor assesses the quality of service against the criteria of accepted medical standards. Section 26 purports to make it clear that the inspectors inspect to make sure the facility meets the legal requirements of the bill. But when one reads sections 24, 24a, 24b, 24c and 24e, one finds the lines blurred as to precisely what is the responsibility of an assessor as against that of an inspector. Can an inspector question medical practices? Can an assessor question legal status?

There is further confusion as to whom each ultimately reports and in what form. Specifically noted was section 26, which refers to an inspector appointed by the registrar. You also have inspectors appointed by the director and you also have inspectors, I presume, appointed by the minister. One wonders about the qualifications of a medical person to judge legal applications involved in a statute or, similarly, how a lay inspector acquires the knowledge to judge medical criteria.

It is my position that the bill should make it crystal clear that the director is responsible for monitoring the facilities to ensure compliance with the act and its regulations and to ensure that proper medical standards

are met and that the minister is totally responsible and answerable for the establishment of the facilities and, of course, is ultimately answerable in the Legislature for the operation of such facilities.

1520

As it is presently worded, it appears that the act, in too many instances, allows the minister to hide behind the skirts—or trousers, as the case may be—of the director. Let the minister call for proposals. Let the minister decide who will operate the facility and where it will be established. Then let it be the director's function to make sure the facility operates properly in accordance with the provisions of the bill and its accompanying regulations. Let the director report any perceived noncompliance to the minister for action and decision, with the right of the parties to appeal to the courts.

That leads me to my final concern, which is the establishment or utilization of yet more quasi-judicial bodies, with their apparent inherent right to create their own precedents and modus operandi.

I was particularly intrigued with section 18, where the appearance of an appeal mechanism is dangled to comfort the gullible by providing that a party has the right to appeal a decision by the minister to cabinet, asking the minister's colleagues to overrule the minister's decision. I am not politically naïve enough to believe that such a ruling by cabinet would not create an untenable situation for the minister, with the whisper of political cronyism being heard throughout the land. If justice is to be done, it must be seen to be done, and court action assures such visibility.

Again, that is the sum and substance. You have a copy of my brief, which I have forwarded to Mr Decker. I thank you for this opportunity. I appreciate the thrust of the bill and I am in agreement with the thrust of the bill. I am at your disposal.

The Chairman: Thank you very much. I must say, in terms of briefs we have had from individual citizens, you have certainly taken the time to study this bill in some detail and provide very specific recommendations. Coming all the way down from Sarnia, I want to thank you for your brief.

Mr Fullerton: My concern has to be that once you begin to establish these clinics—and the federal speech from the throne makes reference to a royal commission which will study the creation-of-life aspects—those are going to be implemented within clinics just as sure as God made little green apples. If that happens, you are going to have situations within communities. You have within this legislation the power to initiate proper zoning within a community, which will ameliorate such situations.

The Chairman: Questions from committee members? I see no hands. Perhaps we could get, however, some comments from the minister or staff with respect to the issues you raised about zoning, because you are not the first person to raise this aspect.

Mr Fullerton: I might point out there is obviously a typo in this. The bill refers to a section which does not exist.

The Chairman: Would you draw it to our attention in case someone missed it?



Mr Fullerton: Section 26.

The Chairman: Bottom of page 4 of his brief.

Mr Fullerton: In my copy of the bill, section 26 refers to subsection 7(3). It either refers to subsection 7(3)—but I do not think it refers to subsection 7, because there is no subsection 7 in that particular section.

The Chairman: Okay.

Mr Fullerton: I simply point that out to you.

The Chairman: We will get someone to check that out. Doctor, could we get a comment, or maybe the minister could comment, on the question of location within communities and the jurisdiction of zoning? It was raised before.

Hon Mrs Caplan: I think there are a number of members of the committee here today who have served on municipal councils. I served, the chairman served, I know that Mike Dietsch, Joan Smith and I think David Reville served. We have all had experience and know that municipalities in fact have the responsibility, through their official plans and their zoning bylaws, to determine what activities will take place in what locations.

It is my understanding that as part of the request-for-proposal process, anyone coming in with a proposal would have to satisfy the municipal requirement for appropriate zoning for the independent health facility in that location and that municipalities will have the opportunity to review, during their site plan, zoning, and actually the issuance of a building permit, the safeguard to make sure that a facility is appropriately located within the municipality.

They will also have the opportunity, through the review of their official plan and zoning bylaws, to make whatever amendments to those —

Mr Fullerton: What I am telling you is that at the present time, in all the zoning planning I have seen, I have not seen any reference to an independent health facility. I have seen references to clinics and a doctor's office. The previous speaker made note of the fact that the clinics would be located in doctors' offices. I could have a doctor's office next to me in a residential area.

Hon Mrs Caplan: Each municipality makes those determinations after full consultation under the Planning Act in its own community to determine what zonings will be permitted to have which activities. From my experience, different municipalities make different decisions following a lot of public input. From a provincial perspective, in the request-for-proposal process and the satisfaction of all of the requirements for the establishment of an independent health facility, one of the requirements will be that municipal zonings, of course, would be adhered to—

Mr Fullerton: It does not say that. That is my very point. Put it in.

Hon Mrs Caplan: —as part of the request-for-proposal process.

Mr Fullerton: Put it in. It does not say that.



Hon Mrs Caplan: I hear your point of view, but zoning is a municipal responsibility.

Mr Fullerton: In response to that, I might point out that we did correspond with your office with reference to this and ask whether a municipality had it within its power to determine what practices a medical or a professional could carry on within an office and the answer was no.

Hon Mrs Caplan: That is correct.

Mr Fullerton: They could determine where the office was located.

Hon Mrs Caplan: That is correct.

Mr Fullerton: I am saying that where you say the minister shall consider (a), (b), (c), (d), (e) and (f), add one more.

Hon Mrs Caplan: Thank you.

The Chairman: I remember when I was on Brantford council—and it varies from municipality to municipality how you define your zoning and how you divide it—the fine point between a hospital and a clinic was whether or not you stayed overnight, not what procedures were carried out.

Mr Fullerton: Exactly, but in all too many clinics you do not stay overnight. I had a friend who flew to Florida for a cataract operation. He flew down and the operation was over in an hour and he was on the plane back. That type of operation is coming along. The previous medical man made reference to the ongoing development of medicine. We are getting less and less staying. You do not have to stay.

The Chairman: Thank you very much for taking the time and sharing your views with us.

Mr Fullerton: I thank the committee for allowing me to appear. I hope it will give consideration to my proposals.

The Chairman: Our next presentation is from the Toronto Psychoanalytic Society. Representing this organization we have Dr Graham Berman, chairman of the ad hoc committee on Bill 147, and Dr J. Szmuilowicz, a member of the ad hoc committee on Bill 147. I have two people listed and I see four people in front of me, so perhaps, Dr Szmuilowicz; you could introduce the people with you.

#### TORONTO PSYCHOANALYTIC SOCIETY

Dr Szmuilowicz: Yes, I will do that with pleasure. Dr Berman could not attend. To my far left is Dr Ian Graham. To my immediate left is Dr Alan Kindler, who is our past president, and to my right is Dr Martha Wright.

The Chairman: You have half an hour for your presentation and committee members would appreciate if you would leave some of that time for questions.

Dr Szmuilowicz: Absolutely. I will try to be brief.

The Toronto Psychoanalytic Society is a professional association of psychoanalysts in Toronto. It is a branch of the Canadian Psychoanalytic

Society, which in turn is affiliated with the International Psychoanalytical Association. A majority of our members are on the teaching faculty of the medical school at the University of Toronto.

The focus of our work is the psychological welfare of patients with both physical and psychiatric disorders. Our work has made us intensely aware of the immense importance that patients attach to the privacy of their medical records.

We believe that Bill 147 poses unnecessary risks for patients by failing to protect their privacy. We will propose certain amendments which will protect the patient's rights to privacy while not impeding the intent of the bill, with which we agree.

Bill 147 covers a broad range of facilities. Potentially, its provisions expose to the public view private health information of any patient in Ontario. A patient innocent of all wrongdoing has no right to avoid the probing eye of the government bureaucracy. The act includes a provision absolving government employees from responsibility for breach of confidentiality while leaving patients vulnerable to catastrophic damage, as will be illustrated later by case examples.

The bill accords inspectors broad powers to inspect, remove, copy and distribute confidential medical information. The inspectors may have a wide range of work backgrounds and are not required to be qualified to understand the medical records or the emotional effects that their intrusion may have on a patient whose record is read, removed or copied.

#### 1530

As written, notwithstanding the comments of the minister a few days ago, the proposed act will encourage the inspector to remove and photocopy records indiscriminately.

The Krever commission demonstrated spectacularly that civil servants bound by fiduciary duty and clear guidelines for confidentiality nevertheless cannot be trusted to respect the sensitivities of the records with which they have been entrusted. Krever found that, as a lark, government employees examine confidential files to discover the names of patients with a sexually transmitted disease, for example.

Human nature is not going to change. We must therefore build into our system the maximum protection of individual privacy that is compatible with efficient functioning. If we do not, it is possible that some Ministry of Health employees, indeed all and any of us, might find their own medical records in a filing system available to their colleagues, supervisors, employees and peers, maintained in central files as well as branch files, photocopied and mailed around by numerous juniors or temporary staff.

In the case of an inspector under the proposed Independent Health Facilities Act, additional copies would be distributed to the financial audit branch if they were involved in the inspection as well as, potentially, the nursing homes branch, home care services branch, lab services branch, ambulance branch, drug benefits branch, central accounts, the Ontario health insurance plan in Kingston, community or teaching hospitals branch and probably many others.

Medical records are too sensitive, patients too vulnerable to idle

curiosity and confidentiality too important to be entrusted to the ministry filing system without safeguards. Every variety of paper document has been lost, misplaced, misfiled and mishandled by government staff in general in the past, both inside and outside the Ministry of Health.

OHIP functions almost entirely on electronic records which are much more easily confined than paper records. There is no comparison between the loss of an electronic file and a paper file.

Of special concern are medical files dealing with diagnosis or treatments that generate punitive and perhaps discriminatory behaviour when disclosed: Acquired immune deficiency syndrome, abortion, mental illness, sexually transmitted diseases, etc. just to name a few. These records would become available to any bureaucrat who requested them, would become a permanent paper record in an imperfect filing system, would become available to other bureaucrats in the Provincial Auditor's office and would, under the Freedom of Information and Protection of Privacy Act—and I believe you will be hearing more about it from Sid Linden—become available to any person who fulfils the requirements of that act.

There is no protection for the patient in this proposed act about how many people learn his identity, diagnosis or treatment or how often these files are examined.

Medical records should be accorded the utmost protection, not to be photocopied or distributed within the ministry or elsewhere, not to be provided to any person without the consent of the patient.

In the proposed legislation, civil servants are exempt from penalty for breaches of confidentiality. Patients may suffer untold harm and have absolutely no recourse. If a physician were responsible for such a breach, he or she would justifiably be liable to civil action and professional censure.

We suggest that any patient whose medical files might be subject to seizure and copying should be entitled to exercise personal discretion about the possession and distribution of such information.

The Freedom of Information and Protection of Privacy Act in section 21(3) states:

"(3) A disclosure of personal information is presumed to constitute an unjustified invasion of personal privacy where the personal information,

"(a) relates to a medical, psychiatric or psychological history, diagnosis, condition, treatment or evaluation."

This clause promises strong protection for the patient wishing to protect personal medical information. Unfortunately, later clauses puncture this guarantee in, for example, cases where the information is useful to investigate or prosecute a violation of law.

Exception to the guarantee of privacy is also permitted when it is conceded that a compelling public interest in the disclosure of the record clearly outweighs the purpose of the exemption.

In other words, bureaucratic and legal decision-makers, notoriously insensitive to the vulnerabilities of the exposed and innocent patient, will be free to use confidential files to seek violations of an act which in no way



warrants such drastic measures. After all, if there is a possible violation of the act, a patient making a complaint, after making the complaint, will presumably consent to the examination of his or her file, making it quite unnecessary that other patients should be dragged unwillingly into the public forum.

A system that allows a regulatory body to investigate complaints, but does not encourage intrusive fishing expeditions has proved adequate to the policing of all the medical services. There is no rational reason why patients subject to the new act should be treated with any less respect.

A request from a member of the public under the Freedom of Information and Protection of Privacy Act requires the office holding the information to conduct a full review of the material, a written report on the contents of the material and a recommendation with detailed reasons about why it should or should not be released. Multiple copies of this documentation are required to be kept by that branch, by each successive superior office, by the freedom of information co-ordinator and again in central files. As demonstrated earlier, the capability of the ministry or any large dispersed organization to guarantee privacy in these circumstances is limited.

Let me give you some case examples.

A physician who has his own lab on site conducts routine blood tests for acquired immune deficiency syndrome. His patients might be charged a technical fee for the lab services and the fee itself may be recorded in the patient file, which also contains the test results. Upon seizure of these records by ministry inspectors, the government may well conclude that the only way to demonstrate to a court that a fee was charged is by admitting as evidence the lab documents that generated the fee.

This information then becomes a public record. The patient may have his life totally disrupted as he becomes a victim of the gamut of public prejudice. Nothing in the proposed Independent Health Facilities Act protects a patient's privacy in this respect.

A large group practice that offers additional noninsured services, such as psychology or numerous other allied services, might charge an administration fee for such services as compensation for the overhead and organization investment. Upon seizure of the billing records, the government may ask the court to decide whether those patients who actually received psychological counselling were appropriately charged. In such a case, all the medical records again become court documents and open to the public. Political and other careers have been destroyed through public misunderstanding of leaked confidential psychological treatment records.

A medical practice that offers special clinics—this is another example—counselling groups, health information and education sessions for family planning and sexually transmitted diseases, abortion counselling and follow-up, teenage sex education and counselling, etc, might also charge an overhead fee to patients who participate. Without the knowledge or consent of these patients, their most intimate confidences are copied and distributed among innumerable civil servants, inspectors, auditors and reviewers.

Let us then propose some amendments for your consideration. We emphasize, in proposing the amendments, that the essential licensing and regulatory function of this bill will not be impaired by the introduction of more adequate protection for the privacy of the innocent and potentially vulnerable patient.



It is true that Bill 147, in section 30, contains some provision for seeking patient consent, but this applies only after comprehensive information has been collected. It is important to recognize rights of patients under section 26, that is, before their medical files are seized and during the time they are held. Therefore, we propose some amendments to section 26 that would come on page 23 as subsection 26(7). Our amendment would read:

"26(7)(a) Any patient whose medical files contain information considered by the appointed inspectors to be relevant in determining a breach of this act shall be afforded the opportunity to refuse the release of his files; and

"(b) In no case shall a patient's identity, medical history, diagnosis, treatment records, condition or assessment be construed as essential to any proceeding under this act, and the copying or distribution of such information by any person is prohibited without the consent of the patient.

#### 1540

"8(a) If information pertaining to a patient's identity, medical history, diagnosis, treatment records, condition or assessment has been improperly gathered under the authority of this act, a patient and his physician shall be notified and all copies immediately returned to the physician and to the patient with a list of every person who has had possession of that information.

"8(b) Every patient has the right to pursue, through applicable legal actions, any breach of his privacy or the confidentiality of his medical records arising from negligence on the part of any official functioning within the authority of this act.

"9(a) Where a clinical record is to be reviewed for the purposes of this act, such review, copying, summarizing and assessments shall be conducted solely by a qualified physician"—I understand the minister has agreed to that amendment—"appointed by the minister and the College of Physicians and Surgeons.

"9(b) Where a clinical record is transmitted or copied for use outside the physician's office even by inspectors appointed by the college, the inspector, assessor or officer in charge shall, before leaving the physician's office, remove from the part of the clinical record that is transmitted or from the copy, as the case may be, the name of and any means of identifying the patient.

"9(c) Where a clinical record is disclosed to or examined by a person for the purposes of this act, the person shall not disclose the name of or any means of identifying the patient and shall not use or communicate the information or material in the clinical record for a purpose other than required under this act.

"9(d) No clinical record shall be removed"—this is important—"copied or summarized for use as evidence in any proceeding under this act without the express written consent of the patient, who is also permitted to see and keep a copy for himself.

"10. Where a clinical record is removed, copied or summarized for use as evidence in any proceeding under this act, the patient shall be given the names of the individuals who are in possession of this material, and also the names of any individuals who at any time request copies of, or access to, this material, whether or not the request is granted."

This has been respectfully submitted.

The Chairman: Thank you for your presentation. I just wanted to note that in the concluding section of your brief, you were actually reading from proposed amendments and there were two places where you deviated from the written copy I had and I just wanted to clarify that, because they are proposed amendments that someone may want to pick up on. In clause 26(8)(a), you added verbally "and his physician shall be notified and all copies immediately returned to the physician," and you said, "and to the patient." You intended that to be part of the amendment?

Dr Szmuilowicz: Yes.

The Chairman: And then the last one I noted was in clause 26(9)(d) on the last page, "the express written consent."

Dr Szmuilowicz: Written consent, yes. Please, could you add that to the record.

The Chairman: Questions from committee members, beginning with Mr Reville.

Mr Reville: Thank you for your presentation. It is very specific. I take it that you are not comforted by the ministry's assurance, which I do not actually see in the bill, that assessors will be the College of Physicians and Surgeons of Ontario people. That does not reassure you enough?

Dr Szmuilowicz: No, it does not.

Mr Reville: It probably would be useful, Mr Chairman, if we could request that the legal branch examine the amendments of the Toronto Psychoanalytic Society and report back to us on your view. What it has suggested is adding a number of subsections to the section on inspections. Perhaps it is unfair to require an instant analysis of this for your information. We have until Monday evening to do public presentations and then next week, we will looking at the clause-by-clause.

The Chairman: That is something that could be reported to us on Tuesday morning.

Mr Reville: If they could report back on some early occasion and you will have the benefit of knowing what they had to say eventually. If you want to show up, you will be welcome too.

The Chairman: You did not have a question?

Mr Reville: No, I had a speech.

The Chairman: That was all right.

Mr Carrothers: You have raised a point on the freedom of information legislation, which has caused me some confusion because I thought actually that legislation was not going to apply to medical records. I am wondering, with your indulgence, whether I could ask the ministry for a comment. Is that legislation going to apply? It seems to be the basis for a great deal of the commentary here.

Mr Sharpe: The legislation, the Freedom of Information and

Protection of Privacy Act, will not apply per se to licensed clinics or certainly unlicensed places like doctors' offices, but I understand the doctors' concern: It is that if inspectors go out and collect information and the information is then incorporated as a government record for use in evaluating the clinic or deciding on prosecution or setoffs, then that information, now belonging to the government, comes under the freedom of information act. Is that correct?

Dr Szmuiłowicz: Yes. You are absolutely right.

Mr Sharpe: In that sense, the information could be caught, but of course the freedom of information act does have a number of protections, one of which would require that patients' consent be obtained before any disclosures were made.

Dr Wright: Is that not after the fact? After you have already gathered the information, you take it to the freedom of information bureaucracy to decide whether you should have gathered the information. It has already been gathered; the breach has already happened.

Mr Sharpe: My understanding is that like the other statutes that the ministry has for inspection of licensed premises—and the ministry has gone through a number of them today: nursing homes, labs, ambulance services, homes for special care and so on—it is important that information be gathered to determine whether the facility is operating in accordance with the licence's conditions, with safety provisions and so on. So that would be an exception to the rule on collection of information under the freedom of information act. Then once it is collected, as I have said, the rules of freedom of information would apply so as to prohibit the ministry from in any way dealing with the information except in accordance with enforcement of the legislation unless knowledge and consent of the individual to whom it relates is obtained. In fact, I notice some familiarity in section 9a with the Mental Health Act. I think you probably took a number of those verbatim from the act.

I think earlier today the minister did talk about the omnibus confidentiality review that is ongoing in conjunction with Mr Linden from the freedom of information office. Many of the issues you raise are part of that consultation process, but certainly we will do our best to look at each of your amendments and report back to the committee.

Dr Szmuiłowicz: If I may, you really cannot close the barn after the horses have left. The Honourable Mr Justice Krever shows the difficulty very, very clearly. He found an appalling lack of confidentiality in medical records. My patients, I am sure, would not safeguarded by your telling me that the freedom of information act will actually make sure that those records available in the ministry files will not be made available to anybody, because they have already been made available to a whole lot of people within the ministry. That is my concern.

Mr Sharpe: I am just going to add that I do not know how comforted they would be, then, by the provision in section 30 requiring secrecy with quasi-criminal penalties if there is any breach.

Hon Mrs Caplan: As well, the other side of freedom of information is the obligation of protection of personal privacy and the fact that this act is consistent in approach for licensed facilities with other pieces of legislation. The unlicensed facilities, as you know, would be subject to exactly the same procedures which are already today—it is the right, as you



know, of the ministry, where there is a concern about OHIP billing, to have assessors.

Bob, maybe you could just explain what exists today and what this act permits for unlicensed facilities and speak specifically to the cases that have been identified.

Dr MacMillan: Some of the presentation might have been drafted prior to the amendment wherein we have protected unlicensed facilities or doctors' offices by virtue of continuing with the same system that has occurred for the last 100 years. To my knowledge, as yet, I have been unable to hear of a breach of that confidentiality on the part of the college. The college will be the only inspectors for unlicensed facilities, so a doctor who may be deemed to be billing a patient inappropriately may be subject to an inspection, but it will be by the same people to whom he is subject to inspection right now for possibly inappropriately billing OHIP; that is, someone appointed by the College of Physicians and Surgeons of Ontario.

1550

As far as the examples the minister asked me to comment on are concerned, I cannot quite follow these examples. I am sure you can find some better ones. You cannot do AIDS testing in a doctor's office, as you probably recall, and any charges for administration fees or overhead fees are clearly inappropriate anyway. I cannot quite understand the example you have made with the administration fee for psychology in relationship to a psychiatrist's office.

Dr Szmuiłowicz: We are trying to bring your attention to the fact that whenever there is a licensed or unlicensed facility—it does not really matter—where there is any kind of suspicion, the way in which the inspectors are going to assess that is by removing material. If I may respond to your 100 years of tradition comment, you will know that there are really three instances where the college can really come into any doctor's or any clinic's offices. One is when the patient complains. But if the patient complains, the patient has given the college an implicit—if not an explicit, because many patients do not actually know—permission to go and look at the records.

There are two other occasions when the college will have the prerogative to come into a clinic. One is on a peer assessment and peer review. I cannot recall, just as Dr MacMillan cannot recall, any case, and I have studied them, of records that have been taken away on a peer assessment case. In many cases, in the case of psychiatrists and psychoanalysts, we have been allowed the prerogative of actually blanking out the name of the patient. The same applies to the medical review committee. I cannot recall, except perhaps for really counted exceptions, an occasion when a government official or the college has actually taken away medical records and lost them somewhere. It usually happens within the confines of the physician's office and there is usually a reason for that. We are concerned that, for no reason, fishing expeditions will go on that will affect everybody's confidentiality.

Hon Mrs Caplan: I would just ask Gil, because the concern you have raised around fishing expeditions I think has been addressed in the act.

Mr Sharpe: The only comment I was going to make is that section 24a of the bill deals with the authority of the director to ask the college to intervene when dealing with unlicensed premises, essentially doctor's offices. There, we have written in the concept of reasonable grounds for belief, which



of course in law is well developed: you must have reasonable probable grounds, for example, if you are a police officer attempting to get a search warrant or whatever. That concept places a legal obligation on the director for which a director would be accountable only to act where there is a reasonable ground for belief.

Then the registrar of the college is asked to appoint someone to go in and take a look at the material; presumably, he would take only that material away that was a direct indication of some offence. The college would have no interest, or, in my view, any right to go fishing through the records to look for anything but what is set out in subsection 24a(1), which is a breach of section 3 of the act.

Dr Szmuiłowicz: The interesting thing is that we seem to be agreeing. If we are agreeing, then why not give the patients the added benefit by just adding the clauses we are asking for, and tell them beforehand when you are going to look at the records? That is all we are asking. If we are agreeing, if it all seems like what the minister has said in the amendments, then make it clear; just add that, which we agree on, and make it clear.

The Chairman: We were still with Mr Carrothers. I recognize that a good deal of your half-hour has been used for ministry clarifications, so I will be extending the time so we can get in all the questioners here.

Mr Carrothers: Just one more brief question. In the proposed amendments you are talking about getting permission, and I guess you are talking about releasing copies of records to patients and so on. I do not see anything in there dealing with the situation where it might not be deemed medically appropriate for the patient to see and know the record. How would you handle that?

Dr Szmuiłowicz: An assessment would have to be made as to the advisability of that, but all in all we are all aware that the patients have the right to look at their records unless it would be damaging for them to do so.

Mr Carrothers: I have dealt with that in the legal context before, where files being collected, in this case by insurance companies that were paying for treatment—The company was coming up with policies on how to deal with the release of those to its own patients; in context, perhaps not too different from what we are talking about. It was very clearly asserted—the medical practitioners involved were adamant—that the company not release that information to patients without going back through them. I am just wondering how you would build that kind of concern, because it must be a real concern. It was certainly very vociferously put to me by the medical practitioners involved at the time that those were being drawn up. I do not see anything in this wording that would have that kind of loop, if you will, to deal with that problem.

Dr Szmuiłowicz: You have a point. Perhaps we should have added something about prior assessment. To do something indiscriminately without looking at individuals—We are looking at individuals, not at a system, so we would have to judge that patient by patient.

Hon Mrs Caplan: I would like to comment, because there was an inaccuracy I would like to have clarified and on the record.

It is my understanding that patients do not have the right of access to

their records, except in the circumstance of our psychiatric hospitals. It is one of the recommendations of Mr Justice Krever and a consideration as we develop the policies of the omnibus bill. I would like that clarified. Gilbert, would you clarify that, please?

Mr Sharpe: The other concern I might just mention—I am sure you are aware of the submission before Justice Krever of both the Ontario Medical Association and the Ontario Psychiatric Association, that perhaps an absolute right of access by patients to records, particularly psychiatric records, may not be wise; and if there were to be such access, it then should not be unfettered. There should be an ability for, say, the psychiatrist to indicate in some circumstances that there is material that must be protected. We have attempted to do that in the Mental Health Act.

As for other facilities, of course, like public hospitals, the Public Hospitals Act does not reflect a right of access; it is at their discretion.

The only question I might pose and something, again, pursuant to Mr Reville's comment that we will look at and perhaps bring to the committee for discussion later on, is that if you had to go to patients every time you were purporting to collect information and then, once collected, use it in some fashion, there might be some concern—for example, if some of that material were psychiatric assessment—that it would require perhaps disclosing to patients matters that could cause serious harm to them or some other people. This again is a theme that the Ontario Psychiatric Association has brought again and again to the ministry and we would have to be very cautious about that.

Of course, there is also the concern that so many of our statutes involve enforcement provisions of licensed premises without being hampered by the need to find patients, explain things to them and get their consent. So there is that secondary concern as well.

Dr Wright: I would just like to respond to what you are saying, though. First, I think most physicians would feel that medical records, whether they are the physician's documents or documents of other members of a clinic, that are used in treatment of the patient, are many times not written or presented in a way that is meant for the patient to read; they are written not in any hostile way, but in a medical way and specifically with the aim of helping those who are doing the work.

So I agree with you. Personally, I think that all records should not automatically be returned to patients. However, I think there is something quite interesting in your logic. You think it would be okay for me, say, as a patient. Do I think it is okay for you to read my records without my being able to read them? It is one thing for my physician, his or her staff and the people to whom I have decided to entrust what I am saying, but for them to read those records and talk among themselves is another whole thing for me as a patient or for my family—I speak from a family that has been severely impacted by release of medical information, for a whole generation—to have some bureaucrat have access, who is not trained, who has a very limited sensitivity to just how easy it is for somebody to identify, from just a few fragments of information, who that document is about.

1600

If you think of the damage that those records are going to do for the patient to read them, I can assure you, as a patient, how much damage was done

to my family and to many other patients to have a lot of eyes see their chart.

Is that really protecting the public? It is in the name of protection, but I think that with the rise of the state and the need of the state to control everything, the individuals involved—all of the people here are going to be patients some time—should think about what the impact is on the individual. Does the greater need of government supervision have to be done this way?

Mr Sharpe: I do not want to belabour the point except to reiterate the notion that this act is set up as so many of our other statutes, with a view to enforcing quality of care and illegal practices in clinics licensed and unlicensed, and to use peer reviewer wherever possible. All legislation, including proposals of Justice Krever—who, by the way, is working with us on the broader confidentiality notion we are hoping to have in the next few months—even he suggests that some limited exceptions to the need for patient consent to disclose information, to access information, must be recognized.

The best way we felt we could approach the concern of improper disclosure was a quasi criminal penalty section, as we have done in section 30, coupled with the responsibility of the minister and cabinet and government to ensure that those for whom they are directly responsible behave appropriately with proper directives, guidelines and so on. Again, as I have said, certainly many of the concerns raised are very important ones. I would hope we could review them and have some recommendations for the committee next week.

Dr Wright: With respect, though, I think rationalizing that this act is going to be doing the same as your other acts is missing the point. Perhaps you should be reviewing the other acts as well as to whether they really are protecting the individuals involved.

Mr Sharpe: Actually, we are. We are reviewing all statutes, in effect, all government statutes, that deal with confidentiality of health care information, and hope that what we will have is an omnibus bill that governs health care information, no matter where it is kept. We will deal with the matters of freedom of information principles and access issues and protection of privacy and so on.

We are looking at all of these issues, and we are consulting with Mr Linden and Justice Krever and any of those we can find who we feel can provide us with important information and input, because there is inconsistency now. We have a Mental Health Act with a right of access, and other legislation, like the Public Hospitals Act, without. We are hoping to move fairly quickly on the more general provisions.

The Chairman: I would like to move along so that we can conclude your time and get to our next delegation. We still have three members who wish to ask questions.

Mr Jackson: My general question was covered by Mr Reville; requesting a legal response to each of the points raised. But I have previously asked the question about notification of the patients; the more we get into this, the more I realize how complex that really is in terms of advising them.

Your recommendation 8(A): What did you envisage in terms of information pertaining to a patient's identity improperly gathered under the



authority—How would we even get a handle on that? I get a sense that the only person who would know it was improperly gathered was the government.

Dr Szmuiłowicz: It is possible that the patient himself or herself will know by seeing your name in the newspaper.

Mr Jackson: I wondered if that was what you meant.

Dr Szmuiłowicz: That is what I meant.

Mr Jackson: Quite frankly, if it is possible still, I did request last week, that we get an opinion from the Attorney General's office with respect to this bill which is separate and distinct from the legal counsel within the ministry. That request is in Hansard, and I would hope that people are pursuing that. I wanted to know if in fact an opinion had been rendered by the AG's department and, if so, what it was.

The Chairman: An opinion with respect to what?

Mr Jackson: The whole issue of confidentiality, the provisions, as I recall from Hansard, for notifying a member of the public whose records had been removed improperly or had become public knowledge.

The Chairman: Just so your request can be specifically checked, do you recall what day you made that request? Is that on the very first day?

Mr Jackson: The day the Ontario Medical Association made its presentation, I immediately followed with two requests for those legal services. It was with respect to the issue of notification. I appreciate very much the group this afternoon putting it in clausal form and bringing it again to our attention.

Mrs Cunningham: Thank you for your presentation. I am wondering how strongly you feel about 9(B), on page 8 of your brief, the handling of clinical records. I am sure you thought a lot about this. I can address the question to you, Dr Wright. I am sure you thought a lot about 9(B). Do you think if the name is deleted the ministry will still get the kind of information it needs?

Dr Wright: Need for what?

Mrs Cunningham: The name and any means of identifying the patient. By the way, I am agreeing with you. You must have thought a lot about this. Could they still get the information they need, given what you know about assessing the quality and standards of care in an audit? Do they need the name?

Dr Wright: In terms of quality and standards of care, I think the only time you would actually have to identify the particular person, it would not have to be by an identification that somebody else could use. You might have to be able to link that person's record with some other record. That could be done through a number system that would be destroyed later, but purely to link up the various records so you know you are talking all about one patient.

If it was a matter of standards of care and it was going forth that this patient was inappropriately treated, you would have to be sure you were talking about the same patient. If you got records from another hospital, you would have to be sure they are indeed commenting on the care of that specific



patient. But other than that, I would not see any reason why any personal information per se about the patient or the patient's name is necessary for the government to assess the quality of care. I would certainly think perhaps some of the medical information would have to be there.

Dr Szmuiłowicz: It happens, unfortunately. It happens in present statutes about governing other inspections. It happens that even if the name is not needed, the name is taken with the file.

Mrs Cunningham: It would be all right with you, and you have obviously thought this through, that an inspector look at the name but you just do not want those names copied. Is that what you are saying?

Dr Szmuiłowicz: No, it would not be okay for the inspector to look at the name unless the inspector has asked for the patient's permission first. That is what we are saying.

Mrs Cunningham: That is the distinction.

Dr Szmuiłowicz: That is what we are saying. The inspector will ask for permission, and if the patient says yes, the inspector can look at the record. But as an added safeguard, we are suggesting that if the record is taken away, take away the name of the patient so that at a later time, even if the patient has agreed, the patient's name is not kept in some government file.

Hon Mrs Caplan: I think there is important clarification that might be helpful, Gil.

Mr Sharpe: I am just going to point out page 24 of the bill with the proposed amendments included. In the proposed section 29a—it is set out to the committee members as motion 26—it is being proposed that there be a means to reimburse patients who have been improperly charged facility fees by private practices.

Dr Szmuiłowicz: Could you tell me again what page you are reading from?

Mr Sharpe: That is page 24 of the reprinted bill.

Dr Szmuiłowicz: Yes, and what clause?

Mr Sharpe: The only concern I raise is that if there were a provision requiring that there be a deletion of the identity of patients when the records are removed for review, there would obviously be great difficulty in knowing whom you are dealing with for the purpose of reimbursing them where ultimately it was decided that they had been improperly charged certain fees.

1610

Hon Mrs Caplan: Just to clarify, because we are talking about what exists today, as you know, there is the opportunity to reimburse. This bill contemplates that where somebody has been improperly charged a facility fee in an unlicensed facility and it has been proven that in fact he was, there is the opportunity to see that he is reimbursed for those charges.

Dr Szmuiłowicz: But presumably that will happen in cases where somebody writes you a letter and says, "Clinic such-and-such has charged me." At that time the patient is actually giving you implicit permission to go.

Otherwise, we have dealt with the fishing expeditions. We have said that they will not occur, so that kind of thing will probably not occur very often.

Dr MacMillan: You are correct, under the Health Care Accessibility Act it only comes with a declaration of the patient, but with Bill 147, if it becomes law and an inspection gave evidence that 100 people had been billed for services that were in breach of this legislation, we would know the names of those 100 people and would send them all cheques.

Dr Wright: However, in your financial concerns for the patient getting however many dollars back, I think perhaps you should look to the public to see whether in fact that is what its concern is. If it were me as a patient, or my family, I would not want to get a letter from the Ministry of Health office handing me back some money if I did not wish the Ministry of Health office to know that I had even been to that clinic. I find it particularly odious that you think patients would like to have their records or the fact that they have even been to, say, an abortion clinic or whatever distributed to a government agency, whatever it is.

Hon Mrs Caplan: We are talking about an unlicensed facility, a doctor's office where a patient has been inappropriately charged and there has been a complaint or, through the auspices of reasonable and probable grounds, that information is determined. This bill allows us to reimburse the patients for those inappropriate charges. In a licensed, independent health facility, the obligations of the licensee for ongoing maintenance of its licence will have to ensure that there are no charges, and of course, as in all licensed facilities, it would be subject to the kind of ongoing monitoring to ensure that no inappropriate charging was taking place, because it would be receiving the funding from the ministry.

It is in unlicensed facilities where you would have this situation and where an assessor, appointed by the College of Physicians and Surgeons of Ontario, with reasonable and probable grounds determined that someone had been charged. If in the course of that investigation that was the practice pattern, there is the opportunity to reimburse those people who also were inappropriately charged fees, so those fees could be returned.

Dr Wright: I think the point you are missing is fundamentally that if you charge somebody and it is proven, hopefully in a court of law rather than by some quasi-legal group, that he is guilty of charging people inappropriately, then there should be some way of notifying through the press, as there is in any other illegal behaviour, that this person has been charged and that anybody who has been inappropriately charged is free to come forward to claim for money back if he wishes to. However, that at least allows the individual who has used those services, for whatever reason, the choice of whether or not he wishes to be known by the state. I think your assumption that people wish the state to be interfering with their private medical concerns and would be quite happy with your messing around with their documents in order to prove that somebody has or has not committed such a crime is not held by the public. They are not going to be happy with that.

The Chairman: I think your point has been made quite clearly, and I think the ministry's point too. My concern as chair is that we move along.

Mrs Cunningham: If I can just make a comment, since it is my question time that is being used, I had another question but I will just make a comment. In all seriousness, one should be taking this particular point very seriously.

The Chairman: I was not suggesting that the committee is not taking it seriously.

Mrs Cunningham: I am not suggesting we are not getting serious responses. In fact, the minister has said that she would look at it and that she would report back on it.

I know we are arguing back and forth on this, but I can assure you, as a person who has been hired by the government in my other life not very long ago, involved in audits that involve people's lives—I am now talking about family benefits and other acts; I am now talking about education, students' records—we do have a problem in accessing family information. The other acts are not perfect. They leave a lot to be desired.

I would think this particular bill has an opportunity to show some leadership. Since you are doing the kinds of discussions in your own arena, probably for the first time, you should seriously look at clause 26(9)(b) and try to look at some kind of identification system that does not give people's names. The only reason you are not hearing from people from family benefits is because they would be scared stiff to come forward and stick up for themselves, they really would.

Given the information that we take, none of it has been libellous in the sense that anybody means to hurt anybody, but when you are trying to prove the kind of housing people live in, what kind of money they earn and filling in all the government forms, you have the names. During an audit, in order to prove your case—otherwise you are administering the policies of the minister effectively—in a program audit you take away samples of families, how much money they earn, what their children are, and there are always records attached. If the families ever knew we looked at it, they would be so shocked. You could still do the same work if that system had been numbered by a person in the office whom they trusted.

I am telling you it is happening. We do not want to be, at the other end, fining people. So I am saying, if you want me to come in and chat with you and give you examples, I will be happy to. I have often wondered why we have not been in more trouble as a government with people's lives. I think it would be awful to have to go to the courts, fine people, go through this whole system and drag family life through the public arena if we do not have to.

Here is a wonderful opportunity, because with this particular bill I think we will be dealing with a much more sophisticated audience. I know you are impatient, but—

The Chairman: Mrs Cunningham, you are making some excellent points and I am sure when we get into clause-by-clause discussion, you will have ample opportunity—

Mrs Cunningham: I do not want the delegation members to go away thinking—and I was getting the feeling—that we were not seriously considering what they were putting forth. I can assure you I would be happy to come in and show you exactly what I am talking about.

In fact, I have people's records in my own home and in my own files, and I should not have them. Neither should other auditors, people who are doing work for the government, have them. That was my job, it was my business, and I can assure you that is exactly what they are talking about. I wonder why someone else has not come and told us about it. So take it seriously and



seriously consider setting an example with this legislation. It is a wonderful opportunity.

The Chairman: I heard a commitment being given that every one of the amendments was going to be looked at and a report would come back to this committee at the time we are considering the amendments clause by clause. We will be considering clause-by-clause the week of 28 August, if you are interested in coming in.

Mr Jackson: Will a copy be sent to the deputants?

Dr Szmuiłowicz: Would a copy be sent to us? I just want to follow up on Mr Jackson's question. Can we get a copy of that?

The Chairman: I am not sure if the report is going to be in writing, but certainly Hansard reports are available to anyone. The clerk will send you a transcript.

Thank you very much for coming before the committee. It has been a very interesting exchange. We have gone overtime with your presentation, but I think it has been useful to illuminate a number of very important issues.

Dr Szmuiłowicz: Just as a suggestion for Mr Sharpe, if he is looking at confidentiality, he might do better to have some real, live doctors looking at real, live patients to help you, because we have a different perspective than just the overall, the perspective of the individual, and that might be useful to you. We would be quite willing to help you out in that.

The Chairman: Our last presentation for today is from the Board of Directors of Chiropractic. Representing this organization, I would like to welcome to the table Norman MacLeod, a consultant, Dr Stanislaw Stolarski, registrar, and Gerard Charette, legal counsel. Welcome to the committee.

1620

#### BOARD OF DIRECTORS OF CHIROPRACTIC OF ONTARIO

Dr Stolarski: Thank you for the opportunity of presenting our very brief presentation this afternoon. I am sorry we were not able to send advance copies to you, but Mr Decker is taking the time now to distribute them. I will wait until each of you has one.

The Chairman: I should mention that you have half an hour and hopefully you will leave some time for questions.

Dr Stolarski: We probably will not need half an hour.

The Board of Directors of Chiropractic of Ontario is the regulatory body for chiropractors in Ontario. Its authority under the present Drugless Practitioners Act is the examination, registration, regulation and discipline of the 1,610 practitioners registered in Ontario.

We understand the Ontario Chiropractic Association presented a written submission to this committee on 10 August 1989 and we endorse the thrust of its presentation.

The board believes that chiropractic services were not intended to be subject to the financial constraints set forth in this and this intent should



be clarified. Therefore, the bill should exempt chiropractic services through the following addition to section 2 of the bill:

"(5) The health services provided by or upon the prescription of a chiropractor."

At the same time, the bill should recognize that a patient should have access to chiropractic health care services at independent health care facilities even though such services may be exempt from the financial constraints set forth in the bill. The board therefore recommends that section 6 of the bill be amended by adding thereto the following as subsection 6(5):

"(5) The director may issue a licence to a person who has submitted a proposal for the establishment and operation of an independent health facility notwithstanding the fact that the health care services to be offered by one or more persons at the independent health facility are not otherwise subject to the application of this act."

Chiropractic services initially became insured services under the Ontario health insurance plan, OHIP, formerly referred to as OHSIP, the Ontario health services insurance plan, on 1 July 1970. At that time the total allowable chiropractic benefits were \$125 per patient annually, with an allowance of \$7 for initial service and a \$5 fee for a subsequent service.

Presently, almost 20 years later, the total allowance has been increased to \$220 annually, with an \$11.75 initial service and a \$9.65 amount for the subsequent service. The OHIP payments amount to only a minor portion of the actual cost of the service. The patient pays the difference directly to the practitioner.

This board has never considered the balanced-billing direct payment as a facility fee. Where an individual has exhausted his or her annual allowance, he or she is directly responsible for the entire fee without any additional subsidization from OHIP.

This board realizes that some services could be exempted, at the pleasure of the minister, under subsection 2(3). It is our opinion that chiropractic services were not intended to be subject to the financial constraints set forth in subsection 3(2) of the bill. Therefore, these services should be exempted in the bill and should not be merely exempted by regulation.

In conclusion, professional services offered by chiropractors are not fully reimbursed under the OHIP system and any ambiguity in the Independent Health Facilities Act should be removed by the addition of an exemption for chiropractic health care services.

Notwithstanding the above, patients should be able to have access to chiropractic health care services at independent health care facilities even though such services would not be reimbursed under the provisions of the IHFA but under existing legislation and policy.

The Chairman: Thank you for your presentation. Questions from the committee? No one has a question?

Mr. Reville: Yes, I will think of a question.

Thank you for your presentation. As you point out, we did hear from the

chiropractic association on 10 August. At that time the minister indicated that the exemption would be by regulation and there was an undertaking that the regulation would be visible to the committee prior to the third reading of the bill, I think. I tabled a couple of amendments that would do what the association wanted, but I am not holding my breath to watch them pass.

You have gone somewhat further than the association did in that you have raised the question of the anomalous situation of the chiropractic, in which the insured service is only a portion of the value of the service and there are limitations and what not.

Dr Stolarski: That is right.

Mr Reville: You have confused me a little bit. I understand the principle. You are suggesting that even though you want an exemption from the bill, you would also like the ability to apply for a licence so that you could provide fully funded chiropractic. Is that not what I heard you say?

Dr Stolarski: There is a possibility of both.

The Chairman: Do you see a contradiction in that request to do both?

Dr Stolarski: There are certain establishments at the present time with which chiropractors are associated with physicians, which in the future may be licensed facilities.

Mr Reville: Right. I can foresee a potential health facility in which there were a number of health professionals involved, some of which were eligible to bill for insured services and some of which were not. Under those circumstances, I presume it would be possible to apply to the ministry for funding that would take those expenses into account, in which case chiropractic might possibly be involved in one of those kinds of arrangements.

Dr Stolarski: Yes.

Mr Reville: You might have a physiotherapist, a chiropractor, a physician or a sports psychologist. Some of those are insurable services and some are not. I do not think there is anything that would prevent that from being a proposal. That is right, is it not?

Dr Stolarski: I think what our board would like clarification on is, if a chiropractor were associated with a licensed health facility, would he be in contravention of the act if he billed beyond what the Ontario health insurance plan allowed; in other words, as he does now?

The Chairman: Do you have an answer for that, Minister?

Hon Mrs Caplan: Bill, do you want to take that?

The Chairman: Try to lean closer to the microphone, if you can.

Mr Sharpe: I was trying, actually, to lean away.

Mr Reville: This is a hard question.

The Chairman: I sensed that.

Hon Mrs Caplan: It is a difficult question.

Mr Sharpe: It would depend on the arrangement. If the chiropractor was part of the service, part of the independent health facility—

Dr Stolarski: He was a member. Say he was a working group within that facility.

Mr Sharpe: Yes, associated with it so that the charges were made through the facility to the government and chiropractic was rolled into that. Then, as Mr. Reville suggested, the adjunctive services, being chiropractic in this case, would be covered under some funding arrangement negotiated between the licence holder and the ministry.

If, on the other hand, the chiropractor had an office in the building housing the independent health facility and there was an arrangement whereby there was some referral of patients, but charging for chiropractic was done independently by the chiropractor directly to patients for the excess amount beyond OHIP—in other words, it really was an independent operation where there was referral—then the chiropractor would not be caught and would not offend the legislation by continuing to practise in that fashion.

Dr Stolarski: There are two scenarios here. There is the scenario where, say, there are five members who own the health facility. He happens to be one of the partners. Okay?

Mr Sharpe: Yes.

Dr Stolarski: There is another one in which he is not a partner. He just rents office space for certain periods of the month; in which case, would he be able to charge over and above OHIP?

Mr Sharpe: I would separate, for the purpose of your example, the ownership of the licence from the provision of chiropractic services. In other words, from a business perspective, he might have a fifth share in the corporation that holds the licence.

Dr Stolarski: Right.

Mr Sharpe: Any individual could be in that position. It is really more a matter of, is he, in addition to owning part of the service, providing chiropractic service as a member of the group? Then, as I gave in my first example, if it is as part of the facility, if the facility, say, is funded globally, just as an example, then his service would be fully funded as an adjunctive or facility fee by the ministry.

On the other hand, if, as you suggest in your second example, it is a matter of renting space and still dealing independently with patients, then no, he would not be offending the legislation. He can continue to practise as he has been doing.

1630

Dr Stolarski: But in the first case he would be offending the legislation.

Mr Sharpe: Yes, if he tried to bill directly to patients for facility fees. That is the prohibition set out in subsection 3(3).

Dr Stolarski: So if you are in partnership, you cannot balance-bill. If you are just renting from that facility, then you can.

Mr Sharpe: No, I did not say that.

Again, I would separate the partnership from the provision of services. If he is a partner and is providing services as part of the clinic, then he cannot bill patients for a component of those services.

Dr Stolarski: All right. On the other hand, if he is only renting space from the facility—

Mr Sharpe: I do not know whether there would be a conflict, in terms of the governing body of chiropractic, for someone to own a piece of the clinic and try to maintain an independent practice with referrals from the clinic. I do not know if there is an arm's-length concern that the College of Physicians and Surgeons might have in that situation.

Dr Stolarski: That is a situation we do not know how to deal with and we are trying to avert this before it occurs.

Mr Sharpe: That would be more the conflict-of-interest concerns that are spelled out clearly, for example, for medicine in the regulations.

Dr Stolarski: You have answered my first scenario. I am still unclear about the second one, wherein he rents space from a facility that is funded by government, provides a chiropractic service and bills OHIP for that portion which is allowable. Is he in contravention of Bill 147 by direct-billing to the patients?

Mr Sharpe: No, I do not believe he is.

Mr Reville: If I may, I thought it was useful to be a bit more free-form because you were getting some useful answers there. You raised a different issue as well which is, are you being properly served by the government in terms of what is allowed for chiropractic services? That is a valid question. It is not a question that we are charged with answering under this exercise.

Dr Stolarski: I realize that.

Mr Reville: But presumably you continue to negotiate these things with the government.

Dr Stolarski: We are the regulatory body of this province, the association—

Mr Reville: You are supposed to be.

Dr Stolarski: Yes.

Mr Reville: Theoretically, one of the ways you resolve that problem is through an independent health facility, where you could envisage a chiropractor being paid a salary that was negotiated with the independent health facility operator. All this billing and additional billing would disappear and depending on how good a negotiator your member was—

Dr Stolarski: It is not so much the amount, sir. It is the principle of where you would offend the act that this board is concerned with because, when we run into situations, it is going to be up to our board of directors to make a decision whether there has been a contravention.



Mr Reville: I think the other recommendation I would make to you is, if you want to cast the scenarios, put them in writing and submit them to the legal branch here, then I am sure they would be glad to give you an opinion on whether you are in or out. The dilemma for us is, how do we draft amendments to render you harmless in those situations where the intent of the bill would want to do that?

Hon Mrs Caplan: Perhaps I could clarify, and it might just assist in what I anticipate will be the effect of the act. By regulation it is the intention to exempt chiropractic services from the act. However, in future, when a request for a proposal is to go out and if chiropractic services were suggested to be a part of that independent health facility then, through those negotiations of the terms of the licence, there would not be the possibility for that chiropractic service to bill in addition to the individual without offending the act.

Dr Stolarski: That would be on an individual basis?

Hon Mrs Caplan: That is correct. They both agree.

So while this act should not affect anybody practising today, there are opportunities in future for those who might be interested in responding to a request for a proposal.

The Chairman: It is great when your staff agrees with you, minister.

Hon Mrs Caplan: I like it when they agree with me.

Mr Reville: If at any time you need anything cleared up, drop in.

Hon Mrs Caplan: I hope that is helpful.

The Chairman: Mr Carrothers had a question.

Mr Carrothers: No, the subjects that I wanted to raise really already have been covered.

The Chairman: Final point.

Dr Stolarski: One other point that counsel raised here—

Mr Charette: It is just the issue dealing with the notwithstanding provision tabled for your suggestion. I think if chiropractic services are exempted by regulation, that is tantamount to saying that the act does not apply to chiropractic services, so I think maybe there is a jurisdictional issue that perhaps there is no jurisdiction to license a facility in which such services are offered.

Hon Mrs Caplan: To clarify—it might be helpful—if there were to be an exemption written into the act, then it would not have the future possibility for requests for proposal to include chiropractic services. Doing it through regulation would exempt existing private practice but allow for the opportunity, under the act, for chiropractic services to be provided in the future as part of a comprehensive request for proposal.

Mr Charette: If that is the intent—

Hon Mrs Caplan: Is that helpful?

Mr Charette: Yes, that is helpful.

Hon Mrs Caplan: They both agree. I anticipated where you were heading and wanted to take the opportunity to tell you how we think the opportunity of doing exemption through regulation will allow for the flexibility in the act to allow for future opportunity for the professionals.

The Chairman: Thank you for coming before the committee and giving the perspective of the Board of Directors of Chiropractic and also for helping to clarify that there is a distinction between your board and the association.

Dr Stolarski: Thank you for the opportunity.

The Chairman: Members of the committee, this concludes our hearings today. However, there was a point raised by Mr Jackson, which I promised to get back to if there was time at the end of the day. Mr Jackson having left, I am wondering whether we should try to find a time on Tuesday morning.

Mr Carrothers: What was the point?

The Chairman: I have forgotten, but I remember promising that.

Mr Carrothers: It must have been very important.

Mr McGuigan: I recall a comment on that question Mr Jackson brought up. I think he was asking—

The Chairman: Oh, I recall it now. It was with respect to the fund-raising by independent health facilities. His concern was with respect to the fact that hospitals do a lot of fund-raising in the community and are we taking away a possible way of funding things? We said we would get back to it. I think we should get back to it when Mr Jackson is present.

Hon Mrs Caplan: For the record, if it would be helpful, since he asked for a written response, what I could do is put it on the record and we could then give him a copy of the Hansard. I have checked with the legal staff who are here and I think it would be quite succinct. They would clarify that this act would permit any nonprofit organization, as well as any individual, to apply or respond to a request for proposal. That nonprofit corporation could have a charitable number and therefore would be governed, regarding their fund-raising activities, by the provisions of the Charitable Institutions Act and the Income Tax Act. But there is nothing in this act that would preclude a nonprofit organization with a charitable status number from responding to a request for proposal.

Mr Reville: I think one of the things that was in Mr Jackson's mind, in so far as it is ever possible to know that, was that hospitals have been successful in fund-raising efforts when in fact they were raising money to buy a CAT scanner. That is sort of an imaginable project where people say, "Okay, great, we should get a CAT scanner," and they all throw their dollar bills in the pot. If, as Dr Bateman suggested, we saw a trend towards those kinds of facilities being offered on a nonhospital basis, what does that do to a hospital board's ability to raise money? I think that was one of his concerns.

Mr Carrothers: (Inaudible) the CAT scanner in that circumstance.

Mr Reville: Maybe they do not have anything specific to raise money for and it is harder to raise it, I do not know. Why do we not ask them?

The Chairman: What I have always felt is that in some communities where you have hospitals raising funds separately, where you have two or three hospitals conducting separate campaigns, it might be an idea that this would be an initiative to get a common fund-raising campaign for commonly understood priorities.

Mr Reville: The Brantford General Hospital is going to join with—

The Chairman: St. Joseph's Hospital, why not? And with an independent health facility.

Mr Reville: Come on.

Hon Mrs Caplan: Just to clarify, once again, since Mr Jackson is here, I think I can—

Mr Jackson: First of all, Mr Chairman, it is customary when a minister is responding to an individual member's question to at least wait until the member has returned.

The Chairman: We were just trying to—

Mr Jackson: Fair ball. Second, I had specifically asked that some examination be made of the differences in the various legislation. If that has all been done behind closed doors or off somewhere and then brought back, that is wonderful, but—

1640

Mr Reville: I do not think it has been done at all. We were trying to figure out what to do with your question and you were imagining what it was; that is all.

Mr Jackson: I can reiterate briefly.

Hon Mrs Caplan: Just for clarification, when asking about examining of other legislation, the intent of this act is not to preclude hospitals from having the opportunity to respond to requests for proposals. Similarly, the preference for nonprofit Canadian corporations is very clear in the act. Therefore, any nonprofit organization, with or without charitable status, could apply and it would not be precluded in any way by the provisions of this act.

Mr Jackson: Yes. What I am asking is, what is missing in the act that I do not necessarily see?

First of all, we understand that currently hospitals raise funds, separate and distinct from the hospitals act. It is under the foundations act, which allows them their charitable number for the purposes set out therein. An independent health facility would not have access to that same piece of legislation.

Hon Mrs Caplan: An independent health facility will be licensed under the Independent Health Facilities Act, but if a hospital was successful in responding to a request for proposal, it could well have access under the Public Hospitals Act and be related to a hospital foundation. They could also be sponsored by, governed by, a nonprofit charitable organization with a charitable number, which would allow them access to community fund-raising

using the charitable number. They could be a nonprofit organization without a charitable number which could still do whatever fund-raising without the access of a charitable number; or they could be a corporate entity or an individual, as the act permits.

There is nothing with this proposed bill that would preclude a request for a proposal from any or all of the corporate structures, profit or nonprofit, charitable or noncharitable, or hospitals under the Public Hospitals Act.

Mr Jackson: I am a nonprofit, which, by definition—but the principals in the operation receive dividends in the form of bonuses because of the efficient operation of the system. Moneys that are earmarked in my application for a licence for capital can be subverted and replaced with fund-raising funds; with moneys that I can raise from public campaigns to raise money.

Does your licensing provision have the flexibility to go in and say: "Look, we have agreed to pay your facility fee based on your fixed acquisition costs for that CAT scan or for that lithotripter, but now in fact you have been able to go out and raise a quarter of a million dollars, which has reduced your cost. I am still paying you a facility fee. That will increase your margin of profitability."

I am seeing an opportunity. Once I lock you into my five years and I have my—

Interjection.

Mr Jackson: Profit or nonprofit, it hardly matters. It would be a lot easier with a profit-making venture. Do you see what I am saying?

Hon Mrs Caplan: I understand. The intention is that the budget for the facility fee component will be reviewed on an annual basis.

Mr Jackson: Right.

Hon Mrs Caplan: The implications of that are that there are annual negotiations to respond appropriately to the ability to provide the service, but I think it is important to clarify that no distinction is made about the ability of anyone—any corporate entity, the charitable status—and this was the point I made earlier. To maintain their charitable numbers, the obligations of charities who have charitable numbers are clearly stated in other acts. As long as they fulfil the obligations that will allow them to maintain their charitable number, they would not be impacted by any provisions of this bill. This bill would permit them to apply and annually their budget would be reviewed.

Mr Jackson: To your knowledge—I think I am paraphrasing your words—you are not aware of any restrictions to these groups. My question is, do we know that, because then a hospital can beat out an independent health facility if an independent health facility does not have an option to go out and raise money locally but a hospital does. My hospital has already put \$1 million in the bank. St. Joseph's Hospital in Hamilton has already put nearly \$500,000 into an account for a lithotripter. It is half paid for. Any independent facility has to catch up to that \$500,000 before it even starts.

Hon Mrs Caplan: One of the provisions of this act—



Mr Jackson: That is all I am getting at. It is not an unfriendly inquiry.

Hon Mrs Caplan: I understand.

Mr Jackson: I see it as a loophole that we should address. That is all.

Hon Mrs Caplan: One of the opportunities this bill permits in the response to a request for proposal is the opportunity to look at all aspects of how the service can best be provided in the community. We have already stated very clearly a preference for nonprofit Canadian corporations. We have also said that we would consider, over the five-year amortization of the licence, the need for how capital is provided. Certainly, the question you raise as far as advantage is concerned, I think would be one that any nonprofit group would want to consider. However, we have the opportunity, in reviewing the request for proposal, to ensure that we have the appropriate standards, the very best professional staff and all of the provisions addressed.

Mr Jackson: We are all in agreement with you on that. I will just simply ask the question this final way: Since this is a permissive piece of legislation at the pleasure of the federal government to grant tax avoidance provisions, can we at least check that those provisions that allow hospitals in Ontario to raise money, through whatever means, can also be utilized—or if there is any lack of clarity in the mind of the federal government—in terms of a clinic operating in a similar fashion? That is all I want to understand.

Can we help a clinic raise money through a charitable approach, which I have been working with my hospital to do? I would just like to know if I can still do it with a clinic. That is a question for the federal government. It is a legal question and it is a simple question. I would really like that to be looked into briefly with a couple of questions.

I see it as a potential impediment or hazard. I would not like to impede some of the positive elements of this bill and I see that as a positive impediment. If a hospital says, "We're going to beat you out for the clinic because we've already got a couple of million bucks tucked away for that piece of equipment," your objective cannot be met because there is always going to be a better proposal from the local hospital to provide it. But that is only on the capital end of it; on the operational end, obviously the clinic will do better. I think you understand the area of my concern. I do not want to debate it. I have asked legal counsel to pursue it.

Hon Mrs Caplan: I understand, but the point you are making is that the hospitals would have an advantage.

Mr Jackson: They would.

Hon Mrs Caplan: I have made the point that any nonprofit charitable organization would have the same opportunity regarding fund-raising as a hospital would have.

Mr Jackson: On quality and all those other elements? You do not know that.

Hon Mrs Caplan: I am saying, given a charitable number, any—

Mr Jackson: We do not know.

Hon Mrs Caplan: We do. I am telling you. The staff just passed me a note that says, "You are right."

Mr Reville: That is an old note.

Hon Mrs Caplan: Any organization that has a charitable number, provided it met the obligations in fact could apply under this act.

Mr Jackson: My question to legal counsel is, can an independent health facility get a charitable number? I think that is the simplest way I can boil down the question.

Hon Mrs Caplan: They are saying yes.

Mr Jackson: So the federal government has a definition of an independent health facility.

Hon Mrs Caplan: No. Any organization that would want to apply to become an independent health facility could apply for a charitable number if it were a nonprofit charitable corporation sponsoring a response to the request for proposal.

Mr Jackson: I would like to see that from the feds before they change their minds.

Mr Carrothers: I would think there is an information bulletin on the Income Tax Act that would answer that question very quickly.

The Chairman: Mr Jackson, before I adjourn, you seem to be upset that we got into this and I want to assure you that I had made a commitment to you that at the end of the day when we finished the delegations we would get back to the question you raised, and I thought you would be pleased when you walked in that we had started to do that rather than adjourn.

Mr Jackson: I did not want to take up the committee's time debating the point further. I am quite satisfied. Legal counsel and I can meet outside and they can ask me what specifically was my problem. A lot of people would like to get home and I do not in any way wish to impede that.

Hon Mrs Caplan: I was going to put it on Hansard and then give you a photocopy of it because you wanted it in writing.

1650

Mr Jackson: I did not want information I was not looking for. Your staff is very busy.

Hon Mrs Caplan: Happy to provide it.

The Chairman: I think we have exhausted the point.

Mr Jackson: There was a second question to be raised with respect to written responses versus verbal responses and that is a procedural matter. It is quite customary to request written responses on matters requested. What we are getting is verbal and I suspect there are written reports on some of these questions.

The Chairman: I am new at this game of chairing a committee. I have only done it since last September. It seems to me that when we do estimates, quite frequently at the beginning of the estimates for a ministry requests are made and written answers are given. My experience with handling bills is that along the way the answers are verbal.

Mr Jackson: Let me explain to you why it is done in the fashion I am requesting it.

The Chairman: The written response are in effect the proposed amendments.

Mr Jackson: When there are legal arguments presented, they, in and of themselves, become the basis on which we can approach legal counsel with amendments to legislation. Legal opinions are not always brought in the form of legal amendments.

Hon Mrs Caplan: That is what Hansard is for.

Mr Jackson: I do not see what the big difficulty is. The staff has to report to someone who will report to us after it has done its research.

The Chairman: You have made your request to the minister.

Mr Jackson: I made it to the chairman. I want to be specific about this. This is a procedural question and it is at the pleasure of this committee. The Liberals wish to say that it shall not be done that way; I accept that. But I am asking you about a procedure, not a convenience to the minister. It is a procedural question, Mr Chairman.

Mr Carrothers: Are you asking for that response to come from the legislative researcher or the minister?

Mr Jackson: Whomever. I would like it in writing, which we can get in most committees. I did not see the nature of the—

The Chairman: Do you want written responses on all the questions you have raised?

Mr Carrothers: We were just dealing with the charitable issue, were we not?

Mr Jackson: No. If you check Hansard for the day the Ontario Medical Association was here, I specifically asked for a written response. That can be checked. I specifically requested today, as Mr Reville had requested from the Toronto Psychoanalytic Society presentation, that those responses to each of those clauses be in writing. That is all. I am not saying everything. I was being specific about those items on which I would like to get an opinion. There was a battery of lawyers dragged into this the first day to say we had all this backup.

The Chairman: Mr Jackson has put this as a question to the committee rather than to the minister, whether we should be getting written responses to his questions. What is the pleasure of the committee?

Dr MacMillan: For a point of information, my manager, who was in the office at 5:30 this morning trying to address some of these questions, would appreciate that unnecessary questions in writing not be requested.

Mr Jackson: That is exactly why I said not all of them.

Dr MacMillan: I have two staff in Toronto on this bill, other than the legal branch, and it is just very demanding.

Mr Dietsch: I was just wondering whether in this particular case there is a need for the response to be in writing. If it is debated and it is in this particular committee and it is on Hansard, it seems to me it is in a written form at that point and it can be easily referred to at that particular time. I appreciate the member's point, but at the second review of the question I have to make sure in my mind that we are not putting the so-called battery of staff to a lot of additional work and spinning wheels on something.

Of course, Mr Jackson would be the first to know that if a lawyer writes a letter, it is generally what one would call a bit at length, whereas when it is given in verbal context and recorded in Hansard, it is on the record in any event. I am not sure in my mind whether it is necessary or not. I would be more inclined to say: "It is on Hansard. There it is in writing. Away we go." Let's not ask for any more and spin wheels unnecessarily.

Mr Jackson: If the chair will entertain not proceeding with clause-by-clause until Hansard is completed and then we have our printed copy to work with our legal counsel on—unless I have to bring our legal people in to listen to a presentation.

Mr Carrothers: I think you have it.

Mr Jackson: What is customary and courteous is simply that if you have it in writing, then you can examine it. You do not have to take up a lot of committee time in unnecessary debate and clarification. I am most comfortable with a system where I contact the staff directly. In most instances, I understand they appreciate it. Then I am not taking up committee time. What facilitates that is a written response. It keeps it as simple as that, as opposed to a long diatribe during committee time. For those members of the government party who are only interested in the government's response it probably does not provide a very fruitful exercise.

The Chairman: I am going to suggest that we take this question under advisement.

Hon Mrs Caplan: The other thing I could suggest that might be helpful is that Mr Sharpe is available to sit down with any members of the committee, including Mr Jackson, to go over some of the legal implications.

The Chairman: Why do you not take his request and consider it and we will discuss it another day? In the meantime—

Hon Mrs Caplan: Sure.

Mr Reville: I think it is totally legitimate for Mr Jackson to ask for an answer in writing and it is up to the committee to decide whether that is appropriate. It is not an unusual request. If it turns out that you are advised by Ministry of Health officials that it is a huge pain in the neck to do it or it cannot be done for X or Y reason or will take many months or something, then you can report that to the committee, but it is not an unusual request.

The Chairman: It just seems to me we are not reaching a conclusion tonight, so let's think about it overnight and address it tomorrow.



Mr Reville: I do not want to think about it at all.

The Chairman: You do not?

Mr Reville: No, I think it is a legitimate request.

Mr Jackson: We will be into clause-by-clause next week.

Mr Carrothers: No, the week after.

Interjections.

Mr Carrothers: I have a very reasonable suggestion. Perhaps if we could specify what the question was, it could be worked out without any difficulty.

The Chairman: Okay. Can you put your---

Mr Reville: We could come back tomorrow.

Hon Mrs Caplan: We are going to be here tomorrow.

Mr Reville: Why do we not adjourn is what I am saying.

The Chairman: We have concluded our business for the day and we are meeting tomorrow. We have a pretty full agenda tomorrow. We have had only one cancellation, late in the afternoon, so it looks like we are going to have to work pretty hard to keep things on track during the day tomorrow. I would appreciate if committee members were to arrive at ten in the morning. See you tomorrow.

The committee adjourned at 1658.

# **HANSARD REPORTING SERVICE**

Room 481, Legislative Building, Queen's Park, Toronto, M7A 1A2

Telephone (416) 965-1456

Index Inquiries: (416) 965-2159

**Editor of Debates:** Peter Brannan

**Deputy Editor of Debates:** Ernie Hemphill

**Editors:** Don Cameron, Chief; Alex Jenkins, Deputy Chief; Edward Patrick, Supervisor; Pierre Beauchamp; Karen Bennett; Liese Binnie; Larry Bruner; Drummond Burgess; Deborah Caruso; Anne Lynas; Wendy Mills-Descheneau; Liz Renzetti; Steven Smal; Janice Spellerberg; Sheila Wawanash

**Reporters (Tape):** Kit Anderson-Knight, Administrator; Margaret Elkins, Wilda Ferguson, Supervisors; Jean Andrews; Sandra Arrizza; Peggy Brooks; Carolyn Brown; Sharon Chalupiak; Danica Dolenc; Margaret Grobicka; Richard Hilson; Barbara Milnes; Sonia Nesbitt; Chantal Perron; Margaret Prince; Mary Sutton

**Reporters (Shorthand):** Pat Girouard; Beth Grahame; Carol McIntosh; Maureen Murphy

**Reference:** Patricia Tolmie, Co-ordinator; Teresa Hamilton; Lynda Middleton

**Index:** Elise Sloga, Chief; Alison Sawatzky

**Editorial Assistants/Printer:** Corrine Marnoch; David Woodruff; Eamon Kade

**Secretaries/Receptionists:** Edith Landry; Ethel Allan

**Messengers:** Stephen Marshall; Mani Pascucci



CA20N  
XC12  
-578

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

INDEPENDENT HEALTH FACILITIES ACT, 1989

WEDNESDAY 16 AUGUST 1989

Morning Sitting





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Dietsch, Michael M. (St. Catharines-Brock L) for Mr Daigeler

Fleet, David (High Park-Swansea L) for Mrs O'Neill

Hosek, Chaviva (Oakwood L) for Mr Beer

Philip, Ed (Etobicoke-Rexdale NDP) for Mr R. F. Johnston

Reville, David (Riverdale NDP) for Mr Allen

Smith, E. Joan (London South L) for Ms Poole

Clerk: Decker, Todd

Staff:

Drummond, Alison, Research Officer, Legislative Research Service

Witnesses:

From the Registered Nurses' Association of Ontario:

Jensen, Elisabeth, President

Watts, Judy, Executive Director

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriole L)

Sharpe, Gilbert, Director, Legal Services Branch

MacMillan, Dr Robert, Executive Director, Health Insurance Division

From the Ontario Nurses' Association:

Bethune, Pat, President

Cole Slattey, Glenna, Chief Executive Officer

Babad, Arlene, Nursing Practice Officer

Nousiainen, Seppo, Research Officer

From the Ontario Coalition for Abortion Clinics:

Harris, Nanci

MacDonald, Cherie

Individual Presentation:

Walker, Michael D., Lawyer, Morris, Rose, Ledgett

From the Scott Clinic:

Corsillo, Maria, Clinic Director

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 16 August 1989

The committee met at 1008 in committee room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: The committee will come to order. There is quite a full agenda today. I will need co-operation from everyone to remain on schedule.

Our first delegation is the Registered Nurses' Association of Ontario. Representing that organization, we have several individuals listed. I will read out the names I have on my agenda: Shauna Fenwick, president-elect; Elisabeth Jensen, president; Judy Watts, executive director; and Mary Wheeler, director of member programs.

Welcome to the committee. Four names; only three individuals. Perhaps you can introduce yourselves. You have a half hour for your presentation and committee members usually appreciate it when you leave some of that time for questions. Welcome.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

Mrs Jensen: Thank you. My name is Elisabeth Jensen. I am president of the Registered Nurses' Association of Ontario. On my left is Shauna Fenwick, who is president-elect, and on my right is Judy Watts, our executive director.

We have circulated briefing notes to the committee in advance. I will go through those notes and highlight them, and I will be adding some points to the information in the notes. We are planning to leave time for questions at the end.

There are approximately 80,000 nurses in Ontario working in many places including hospitals, clinics, public health departments, industry, colleges, universities, visiting nursing services, and a growing number of nurses in private practice.

The work of nursing is to care for the health and wellbeing of individuals and their families in the community and in institutional settings. In fact, the focus of nursing is health, and effective health care resource management is a long-standing concern of nurses.

The Registered Nurses' Association of Ontario, RNAO, is a voluntary organization representing the profession of nursing in its broadest sense in Ontario. We are linked nationally with the Canadian Nurses Association and internationally with the International Council of Nurses. Our membership consists of members from every walk of nursing life including nurses not practising at this moment in time. The largest group of members within our association are staff nurses.

For many years, we have supported community-based primary health care with consumer choice of health care practitioner. That is the philosophic base of RNAO that underlines the policy recommendations that we will be making today. We are very pleased to be here and to be able to present this brief to the standing committee on social development.

While RNAO supports the shift of health care services and dollars to the community, we are very concerned that this act does not at the present time strongly reflect health promotion, nonmedical treatments, counselling or interdisciplinary activities. The act was promoted as part of the health care promotion and move of health care to the community by the Ministry of Health initially, but in order to do that we feel it needs a much broader base than to focus simply upon medical care and medical services.

The act as it stands now would seem to move medical care from a hospital setting to the community philosophically intact, and we feel some changes can be made that would broaden this act, that would in fact bring it into line with the other legislative pieces that are moving forward to support the thrust of health care reform in Ontario. We very strongly support that thrust and that reform is something we have been hoping for for a long time and we are pleased to see that there is movement in that direction.

We did express concerns to the Honourable R. MacMillan in February 1989 in a letter and we feel that many of these concerns have not as yet been addressed in the proposed amendments. Unless the legislation is redrafted or the regulations encourage explicitly a shift to health promotion from illness care, we will see a duplication of the existing services.

We must bear in mind that although in the public's mind medical care is interchangeably used with health care, within the health care system medical care is only one type of care that is provided and it is the care provided by medical practitioners. The health professions legislation will be regulating the practice of 23 different disciplines, of which only one is medicine. So we would see that any legislation that is moving health care to the community should bear in mind there are many other groups that provide care that is part of health care.

As well, these groups have for many years had the explicit message that health care is medically dominated and the medical model is what has been driving the system historically. We believe it is important for these same groups to get a very explicit message that reform is indeed encouraged and welcome. Not simply by not saying the old message will people get a new message.

We believe that this message needs to be very clearly said because many of these people have been told no many times when they have come forward with innovative ideas, particularly community-based ideas. We believe this legislation can give a very explicit message to other health care providers that there is room to expand and go into the community in a broader way than has occurred in the past.

We have attached in appendix C an example of one model of a health clinic, which is in Sault Ste Marie. It is a women's health centre which is operated by a nurse. There are other examples in the country. There are health promotion clinics in Westmount, Montreal, that were put into place under the direction of Dr Moyra Allen of the faculty of nursing at McGill University a number of years ago that demonstrated empirically that nurses operating wellness clinics in the community made a difference in terms of health care

and cost containment. We would like to see this legislation supporting the establishment of those kinds of wellness clinics.

I would like to go over our recommendations. At the present time, we have noticed that the focus is on medical practitioners and medical care and we would like to see this broadened to community-based services by many health care professionals. The act currently defines practitioners in the context of the Health Insurance Act; ie, doctors and dentists.

We would recommend that the Canada Health Act be used as a basis for defining "practitioner" and that the definition in fact be linked to the health professions legislation as it moves forward because that legislation defines in a very full way who practises within the context of health care in this province, what people do and what the scope of practice is for the various groups.

No one group of health care professionals can or should control access to the system. Many people who seek out health care already have a sense in their own mind of what it is they need and what they are looking for, and at the present time are limited to seeking only insured services unless they are prepared to pay out of pocket. That is a barrier for some people and we would like to see that the public is able to access whoever it is it needs to access directly and that the gate should not be controlled by another practitioner.

We also recommend a shift in the emphasis from the high-technology, high-cost system which is dominated right now by the cure approach to health care, and we would like to see a system where all citizens could have equal access to health care, to the provider of their choice and receive services appropriate to the needs in an accessible setting and at an affordable cost.

We believe that all health care providers should be included in both policymaking and the delivery of health care services. Each profession is the expert on its own business and practice, and therefore is the best group to speak on behalf of what that particular group is able to bring to the system. It is when all of the groups come together to contribute and all of the input is taken that I think we will come out with a more balanced contribution to direct future activities.

We support, as some of you know, the egalitarian structure of the health professions legislation review and we believe that in this particular act the balance of power among health care providers should in fact be egalitarian. Our policy on health care reform supports the change in this direction and we are aware that the public supports the move for a more consumer-oriented, more consumer-based system as well.

We have long had a position that all health care practitioners be salaried, and that is a position we continue to maintain. This gets away from the conflict of interest of the provider meeting his own needs and meeting the care recipient's needs as well. So that position is still maintained.

The facility fee disbursement, as currently defined, makes the physician an employer and this conflicts with an egalitarian power structure that we would see as desirable in the interdisciplinary philosophy. Two clauses, as currently written, seem to give the government an opening to fund nonmedical practitioners who are not fee-for-service paid.

We note that section 23, "The minister may pay all or part of the cost of services provided in and the operating costs of an independent health



facility according to whatever method of payment the minister may decide upon" and paragraph 33(1)22, "The Lieutenant Governor in Council may make regulations prescribing services, classes of services and operating costs that are not part of the insured service...." We believe these clauses should define the additional practitioners and the reimbursement methods. Again, it is part of that explicit message that would go to the other 22 care-providing groups that will be recognized under the new health professions legislation.

1020

Quality assurance programs related to patient care must be instituted based on Ministry of Health and local community standards. That is a very important part; that there should always be a way of assuring the quality of care that is provided and that there must be an evaluation of the outcomes and the cost-effectiveness. Accountability must be built in for anyone providing services in these facilities so that the public, which funds the services, is assured of getting value for the investment.

Under recommendation 4, we wrote this prior to a more recent change, and we congratulate the committee on the amendment which recognizes that appropriate colleges would regulate their respective practitioners. That is very much congruent with what we have been supporting.

Under recommendation 5, we support strengthening the role of the district health council so that it can determine community needs and co-ordinate existing services. The present wording within the act suggests that the Minister of Health would be choosing the projects to be funded. We are concerned that this again would weaken that local input and allow people who are very innovative and entrepreneurial to come to Toronto to meet with the minister and argue the merits of their course, when the local people, the local district health council, may already have looked at it and, in light of their knowledge of the local scene, may not have felt it appropriate.

We are very concerned that it actually gives two messages. One is that there is local community-based control, but the other is that there is central control. We would like to see that this becomes more a local kind of decision that is made under the district health council's jurisdiction.

Community health care also requires professionals educated to be autonomous, analytical, interdependent members of a team, and support from the Ministry of Health and the Ministry of Colleges and Universities for the preparation of appropriate numbers of qualified nurses is needed. There is a pilot project proposed by Cambrian College and Laurentian University at the present time that would prepare practitioners who can work equally well in the hospital setting and the community.

At the present time, community practitioners in nursing are prepared largely at the university setting and hospital practitioners are prepared at the college setting. What they are proposing is a different type of curriculum that would allow the graduating nurse a much broader selection in terms of career paths and therefore provide for the public a larger pool of people who are able to make use of legislation such as this to establish wellness clinics, nursing health clinics, counselling clinics, aftercare clinics or community-based supportive sorts of services that are not presently part of the system.

One of the questions our association had as we read through the proposed legislation is, does this act, as it stands right now, facilitate a group of

professional nurses setting up a wellness clinic, a psychiatric clinic or a counselling clinic in a way that we could receive government funding, that we could access the funds that would be overseen by this legislation? Would we be able to do that or would we need to link up with medicine or another discipline in order to be able to set that kind of thing in place?

If the act freely encourages nurses, physiotherapists, occupational therapists or other groups to set up independent health facilities, then I think this is very much a move forward. If it does not explicitly do so, the concern is that what we will see is a continuation of what has been and what we know is not as cost-effective or as efficient and not as much the system that meets the need of the public as what we would like to see. What we would encourage is that this legislation again become part of that thrust for reform that opens up the access to health care for the public.

In summary, we support the need for regulation of independent health and medical facilities. That is the way we assure the public that it is indeed getting that which it is entitled to. However, the potential of the act to operationalize the Ministry of Health and the Registered Nurses' Association of Ontario vision is not realized as currently written. It is our opinion that this act should be redrafted so as to reflect the articulated vision and recently demonstrated political will to alter Ontario's health care in a positive and futuristic manner.

We will now take questions.

The Chairman: Thank you very much for your presentation and for leaving about 15 minutes for questions. We will begin with Mr Reville. I should mention to committee members that so far I have four requests to ask questions.

Mr Reville: I will be as economical as possible. I want to thank the RNAO for an excellent brief. I think you have hit the nail right on the head.

One of the dilemmas is that this legislation, read by itself, is not the mechanism that you seek, I believe. It is not going to foster illness prevention and health promotion. It is procedure-centred. All the discussion about it has to do primarily with high-tech procedures that could be performed in a nonhospital setting: eye surgery, arthroscopic surgery and that sort of thing. We even had a proposal that magnetic resonance imaging could be handled in this way. It probably could, but that does not have to do with illness prevention and health promotion particularly.

If you think the Minister of Health (Mrs Caplan) has credibility in terms of her talk about the way she wants to move the health care system, it is possible that this bill would be of assistance, because it would provide a mechanism to flow money to the kind of health facility you would be interested in. So I do not think you would be stopped from answering a proposal call, although there is a fixation on insured services in the bill and on medical practitioners, which is problematic for me. I am worried that it will not deliver the promise that is being held out, that basically what we are talking about is baby hospitals and that the only the community aspect of them is that they are not in a hospital; it is a geographical criterion only.

You can deal with cataracts in the Park Plaza Hotel, everybody knows that, but that does not change the tone of our health care system. It just expands a tone that many of us think is inappropriate.

You point out that there is an amendment that deals with the registrar problem and that was the 31st amendment the government has brought into the legislation. Most of the amendments do not do very much to address your concerns.

I am wondering if you can help me. I have been sort of struggling here listening to people make the same point that you have, trying to imagine how you would amend this legislation so that it did commit the government to delivering on at least the statements it has been making about its interest in community care and wellness. I do not know how you write that into legislation precisely. One of the ways would be to talk about community accountability and responsibility and the minister has already rejected that. I have asked her about that and she said no, she is not going to build that in. Another way would be to follow your suggestion and expand the list of practitioners involved so that it would not be so doctor-centred. Have you any hopeful suggestions?

Mrs Jensen: I think if you simply expand the list of practitioners, you could end up with adding on at the end. It may be more prudent, if you do not want to spend all day typing, to think about how you define "practitioner" in a more generic kind of sense. I think probably the Canada Health Act and the health professions legislation review could provide language for doing that, so that rather than stating explicitly one or two practice groups, they could simply say that a health care practitioner, for example, may be somebody who is recognized by the health professions legislation. That may be one way to do that. That would then give a message very different from saying, "Physicians and dentists and then whomever else we feel like adding on this week or this year."

My experience with legislation is that once it is on paper and it is passed, it has a very long life in some cases.

Mr Reville: About 10 years usually.

Mrs Jensen: In the case of the Public Hospitals Act, it is older than I am.

Mr Reville: You mean 24.

Mrs Jensen: Thank you. Some pieces tend to be around for a long time.

I think a more generic kind of definition would work better and would give a different message than identifying two groups and then saying, "and others," which also gives a message because the people you are giving the message to, the health care practitioners, have had a very strong other message for a long time. We need to see a strong, different message and it has to be explicit.

Mr Reville: That is a good point. You mention your concern about the approval process, where the district health council can labour mightily, come forth with proposals and the minister can fund any, all or none of the proposals made by a DHC. How would you amend the legislation so that the minister's absolute power is tempered by the community input you are interested in?

1030

Mrs Jensen: I think we would like to see more of the actual authority for the decision happening at the local level. Having worked in the system for as long as I have, what I have experienced is that the people who are very energetic, type A people, very entrepreneurial and very persuasive, tend to generate what they do and it is not necessarily linked to what the need is, but we sometimes find ourselves creating a market based on charisma, personality or the skill of the person driving that.

I think if the district health council is to have that overview, as it looks like it will have in the future, of looking at what all the things are that we provide that are health care, then how does this fit in? They will be looking at the needs in this geographic area and how does this new thing fit in. If it does not fit in and we have to import the patients to support that from somewhere outside, then it is inappropriate that it go forward. But if, on the other hand, there is a large population that needs that, then it is very appropriate that it should go forward. But it should be based on need and not on, "I happen to think I would do a good X and I'm a nice person, so let me go and do it," but based much more on what the community needs.

Mr Reville: There are a lot of people out with a good X already. We have seen some of them come forward without any notion about whether or not it is needed, but they sure as hell can do it. There will be a lot of that, I expect.

Mrs Cunningham: Thank you for an excellent brief this morning. Your concerns I think have been explained to us by other groups. I am particularly interested in exactly the same two points Mr Reville has raised, and that is the role of the district health council. I was intrigued to hear your comment, told, I know, many times.

In calling out to three or four of the district health councils, they have proposals that reflect the needs of their communities, which they have been looking at, they tell me, for over seven years and their first priority on their list for services would still be their first priority whether this legislation was in place or not. A lot of it has to do with what you were talking about, counselling, psychiatric support, those kinds of services in the community. Given the amendment you talked about that the government had put forward with regard to the registrar, it is a little bit different from the wording you used. Have you had a chance to look at that particular amendment?

Mrs Jensen: Very briefly. I just got back from holidays yesterday.

Mrs Cunningham: Okay. The wording is somewhat different, but I think the intent is the same. On page 5 of your brief, point 4, where you talk about the wording change, that it should be changed to "registrar of the appropriate college," that the government has put forward, meaning the chief administrative officer of the governing, registering or licensing body of a health profession, I think it probably would meet your intentions.

Mrs Jensen: Yes.

Mrs Cunningham: I wanted to check that one out and make sure we were on the right track. To my way of thinking, that would mean almost anyone who



belongs to a professional group and who is on the list would be eligible to come forward with proposals. Is that your understanding?

Mrs Jensen: My understanding of this is that somebody working in that particular clinic would be accountable to his own college, which is the case in the real world. What we would like to see when the legislation, as it sits right now, talks about what it is governing—again, it is very heavily medically oriented—is something that is not so heavily bought into the practise of one discipline but would reflect the practise of more than one discipline.

I think there was another part we talked about as well, where the physician could in theory be the employer of the other people in that clinic, which again gets away from the egalitarian functioning of interdisciplinary teams. So I think it is more than a clause that would have to give the spirit of that shift. One clause somewhere in the middle of however many pages this ends up being becomes something one must seek out and find. It should be a thread that goes through it.

Mrs Cunningham: So you are looking for a clause that clearly explains the intent of the interdisciplinary approach to the delivery of health care in clinics.

Mrs Jensen: That is right.

Mrs Cunningham: I think it is interesting that you raise the part about the physician. We have had a number of people come before the committee who have talked about the role of the physician. I do not have strong opinions on this, but I thought it was rather interesting that in one of the proposals that was costed the other day, and you know this, they were costing out the physician's salary and when I asked him how many days he would be there, he could not tell me. Of course, it was a large amount of money and that is the way things are set up now.

If we really looked at what we were trying to do in this province and started over again when it came to setting up costing of this health care delivery, you are telling us today that we do not always need a physician there, and a physician on a piece of paper who is really working somewhere else is not helpful. Maybe someone should be looking at that problem, because they themselves admit it. They are surprised that they have been allowed to carry on in that manner for the number of years they have.

We very much appreciate the points you have been making today. Although I was rather negative and said the whole thing should be rewritten because the tone is not in it, I am not sure how we can deal with it yet unless we do get that tone in. Thank you.

Mr Carrothers: I would like to pick up on the same theme, because I think everybody around the table agrees about the need to expand the nature of health care delivery and move towards prevention. I just want to explore a little bit about where that might take place, looking at your recommendation 2.

I see this legislation as a piece; it is one of a number of laws that make our health system work. In reality, it is a small piece and I think the fundamental nature of our system is contained in other legislation, specifically the OHIP legislation.

You have keyed on section 23 in your recommendation, which I think you have stripped of everything. That is the essential piece of this bill. It is the section that allows the minister to pay operating costs of facilities. It does not specify really what kind of facility, but a facility. It then uses terms like "insured service" from other definitions earlier, which seems to me to relate back to the fact that the operation, the fee for doing a service, the salary or whatever, if you will, will come out of the OHIP system and therefore has to come into these clinics through the payment of an OHIP fee of some kind or another.

I guess what I am coming around to saying is, would it not be more likely the case that the kind of broadened health care service delivery you are talking about would need to come through changes in what we consider insured services, that that is the more important place to make those changes and that perhaps through things like the health professions legislation review that is going on, we will see that happen and that in this piece of legislation, because it is really only keying in on paying the operating costs of a facility, whatever that may be, there is only so much you can add into it without putting things in it which are out of context?

I have a concern about that because I have dealt with legislation and have found that a court, when it interprets it, usually likes to assume that the legislation was logically drafted, and if there is phrasing or things in a piece of legislation that do not relate to the general context of that will sometimes find interpretations for those words which were not what were intended in the first place.

I would like to see the changes made perhaps elsewhere and I am wondering if it is not really in what we define as an insured service. If we can expand that concept, then it would play right into this piece of legislation as drafted and accomplish what you are looking for.

Mrs Jensen: Unless I have missed it, I do not believe there is anything in the health professions legislation that is proposed that talks about insured service. It talks about what professions provide in the way of services, what is licensed, who can do what under what situations and how professions will self-regulate. This is a piece that deals with how services are paid for.

Mr Carrothers: I think that is the point. I think it is how the facility is paid for. The services are paid for some other way, as I read this. That is what I am saying. You are right about the health professions legislation, but what I see it doing is talking about what professions do and that these could change and that as a result of that, we would then look at what is an insured service and change those definitions reflecting the health professions.

This is a piece of a much broader puzzle and what you are talking about would seem to me to be better accomplished elsewhere in the legislation than in making changes to this act, which is really dealing with a facility and almost talking about operating and capital costs. That is the plus that I see coming out of this. At least, that is how I understand it and I guess I am saying that to you and asking for your reaction.

Mrs Jensen: In that case, since we have not heard that the pieces that have to do with that part of the funding are being opened up, we would be

very keen to be back here, ready to discuss that at such time as that comes forward.

1040

Mr Carrothers: Maybe the minister has a comment on that.

Hon Mrs Caplan: I believe that this act is permissive—I will ask both Bob MacMillan and Gil Sharpe to jump in—and I think one of the best examples is the policy change on birthing centres, for example, where under the present payment method you pay for the delivery. One of the reasons the policy of the ministry was not to permit births to take place out of the hospital environment was that there was not the quality assurance aspect of it.

However, in the policy change to permit out-of-hospital birthing centres, the concept there is to have prenatal and antenatal prevention opportunities as part of a programmatic approach in a birthing centre, which is possible today only with an in-hospital setting. That is one example of a policy change and where by regulation we will be able to have the flexibility to expand upon the kinds of programs and services provided in an independent health facility with quality assurance. In fact, I think we will have much greater flexibility to build in both the health promotion and disease prevention opportunities in an alternative setting.

I will just point out—I think that is what my colleague was referring to—that as well as a number of other pieces of legislation there are a number of initiatives that are fostering that important shift to the expansion of community health centres and health service organizations, the policy to look at program funding for those kinds of organizations and the opportunity that community health centres and health service organizations will have in delivering services under this act, because it is contemplated that community health centres and health service organizations will be able to apply to do procedures which at present can be provided only in a hospital setting.

This, again, would be a good complement to the strong health promotion and disease prevention programs that are already in those centres. So it fits together as part of the overall plan. Did I miss anything you want to add? We see this bill as flexible enough to accommodate that concern you have.

Mr Carrothers: I will pass as I think there are other questions.

The Chairman: There are other questions. We have used up the half hour and I remind committee members that we have a full morning, so when we go over it with each delegation it is going to force us into the noon hour. I have three questioners left and am in the committee's hands. Shall we take very quick questions?

Mr Carrothers: Don't put yourself in our hands, Mr Chairman.

The Chairman: I will allow the three questions provided the three members are fairly brief.

Ms Hosek: I very much enjoyed your brief and think that what you are struggling about is exactly what we are struggling about, which is how to move the health care system in the direction we would like to see. But I would have to say that my own understanding is very much the understanding that was just articulated by the minister, which is that there is a variety of means to do



this. We are not going to be able to have a single moment or act in which we will suddenly be there. We are moving in the right direction.

Some of the concerns I was interested in have been raised in the other discussions. In particular, my sense of this legislation is that it allows for one kind of new option among a series of new ones. Community health centres are one. Health service organizations and health maintenance organizations are another. This is an opportunity for certain kinds of services and others along the way so we will have a much more articulated system than we now have. My understanding also is that this would allow for nurse practitioners and other professionals to be in charge of programs and propose things that they would like to do in the community in organizations like this one, but there would have to be at some point access to physicians' services as well.

What I am going to do with the two minutes I have is ask you how the funding in the Sault Ste Marie women's Group Health Centre is actually done. It seems to me that is a model of the kind of institution you would like to see or the kind of option you would like to see out there. Could you tell me how that funding works now and how you would like it to work? That might help us in thinking about what opportunities we want to enable through this and other legislation.

Mrs Jensen: It is my understanding that it is part of the community health centre in the Sault and that it is funded on a capitation-negation system at the present time. The women's health clinic, as part of that larger organization then, is part of its list of broader priorities. What we would like to see is an opportunity for something like that to exist by itself if need be.

To address your concern about access to medical services, within professions, quite often if one needs a particular type of service it is a matter of calling the other practitioner and making a referral. That is the way things are done by and large and in my own practice that is how things are done.

As long as there are physicians in the province, I do not think there would be problems accessing a physician, but we would like to see the possibility of those kinds of things being able to be established independently. If there is not a community health centre in a community as yet, if a group of nurses wanted to establish a wellness clinic, that they could do that.

Ms Hosek: So in a way what you are saying is, because this independent health facility does have a particular tilt towards procedures that have usually been medical procedures and sometimes surgical procedures and taking them out of the hospital into another location, I think what I am hearing you say is that you would like it to be possible for nurse practitioners and other professionals to set up health service organizations of their own, which in other words means broadening access to that kind of institution. It may not be actually covered so much by this bill as by some of the other things we are trying to do. That is my understanding anyway.

Hon Mrs Caplan: In fact, the health professions legislation review, which has been referred to, is not yet in the form of legislation before the committee as government policy. It has not been before the committee and it is the position that in fact decisions taken should not preclude the opportunity for the public debate that will ensue around the development of that piece of legislation.



At this point in time, I am meeting with all the groups to hear their response to Mr Schwartz's recommendations under HPLR, and whatever we do in the future there may result in the need to amend other pieces of legislation to make it consistent, but at this point in time, that act is not law and the policy has not been fully accepted.

The Chairman: We have to move on.

Mrs E. J. Smith: I will also be very brief, because I think a lot of what the others have asked has covered my concern.

I do note with interest, I am sure that you have noticed and I am happy to say that the questions coming from all parties are more or less the same in supporting the general thrust of what you are saying. I think this is a very positive note that you can take back to your association: that all three parties understand where we think health care should be going and we seem to be agreed in the line of our questioning.

One of your comments then, which I think is very important, was the one raised again by Mrs Cunningham about the district health councils. I feel the way they are used throughout the province is extremely important in the development of both responsibility in the central arm, as you say, and yet flexibility to provide services in the areas.

As an association throughout the province, you have an opportunity to see many health councils at work. In London, I feel they are moving tremendously in the direction that you are talking about, that they are taking this role and being very responsive and definitely being used and heard.

Is that general throughout the province or do we need to be further strengthening the role of health councils as we go?

Mrs Jensen: There are, as yet, parts of the province that do not have district health councils, so we have a range from London, which is very dynamic and proactive and moving, to areas such as Goderich-Huron county, and it is not far from London, that has no district health council as yet. So certainly I think there would need to be support for the development of those kinds of local groups. It is my understanding that some of that support is happening in different parts, so that groups can participate in the decision-making around health care in their own area.

Mrs E. J. Smith: Would you see that as the logical way to support your aim to further concentrate on the health councils as a local input?

Mrs Jensen: I think it is a very important way to get that local input. That, as well as advisory councils to these facilities made up of local people, is a very important way to keep any health care agency or group honest in a locale, so that they are indeed providing what they are there to provide.

Mrs E. J. Smith: Indeed, your advisory councils are to the groups which make proposals, whereas the health councils select between proposals; so they both have a different role.

Mrs Jensen: They have a different role, but I think the district health council is key in terms of making sure there is a balance of services and we are not running into duplications, overlaps and gaps as happens at the present time.

Mrs E. J. Smith: Right. Very good. I appreciate those comments.

Mr Philip: I have considerable empathy with your recommendation 3, but I want to ask you a question about it.

Value-for-money auditing: We have probably led the way, at least in the Provincial Auditor's office, but the quality of value-for-money auditing in the ministries and in the field is certainly far from what one would expect if we are going to ensure that the taxpayers are getting their money's worth on each individual program.

I am wondering, since you place some emphasis on evaluation at the local level in recommendation 3, if you have any ideas or recommendations as to how those skills can be developed so that the taxpayers can have some assurance that when money is spent in a more decentralized way that it is being spent wisely.

1050

Mrs Jensen: There are some mechanisms in place now in the health care system. There are quality assurance indicator tools being used in a number of institutions to look at care and there are ways that professionals audit. I can speak best from nursing. We do audit each other's care. We audit charts and if things are not as they should be, the reports come back and there is a push for improvement.

This is always linked to the amount of staff that is on in a given unit. As well, there is an accreditation process within the hospitals where an independent group will come in, depending how long the previous accreditation award was, they will come back prior to the expiry of that. The longest accreditation award is three years; the shortest is one year. Some institutions do not always get reaccredited and they come in independently without any vested interest or bias or emotional link to the institution and evaluate according to independent criteria.

It will be work certainly to get something off the ground and get it started but it is important to have that kind of evaluation and, again, to link it back to the question, is the service the community needs being provided? If we set up a clinic to provide women's health counselling, are we indeed seeing women, are we indeed counselling about health, to make sure that what it is there to do is what in fact it is doing.

Mr Philip: I do not want to get into a chicken-and-egg kind of argument but I guess my question is, are there the auditing skills at the community level of sufficient standards to satisfy you and if not, what do you think should be done about it?

Mrs Jensen: I think they are developing. Certainly within the provider groups, they are developing but my sense is also that the community is becoming much more educated and aware of what to expect in terms of health care and what is acceptable. It is an evolving and growing process.

The Chairman: The minister has a quick supplementary to the point raised by Mr Philip.

Hon Mrs Caplan: You raised one question yesterday before committee, the issue of getting consent from patients before audits were done and peer review was done. In the environment that you work within the hospital setting,

is there any requirement for consent of patient before peer review audit for quality assurance?

Mrs Jensen: Except for the accreditation process, peer review is done by people already employed by the agency and so there is no breach of confidentiality beyond the agency. In the setting where I practise, if I were to communicate with someone outside of the agency about patient care, I do get patient consent for that, but I am governed by the Mental Health Act in that.

Hon Mrs Caplan: What about when the outside accreditors come in to the hospital setting?

Ms Watts: Perhaps also coming from the institutional area recently, I could answer that.

In most auditing or accrediting processes, there is a very strong mechanism to keep it objective, nonspecific patient oriented so that you are looking at a range of services. It is collated data that is put together so it is not feasible to relate it to specific patients, or to specific practitioners, if that is how you wish to set it up too. The work of a unit of people may be audited as opposed to an individual.

Hon Mrs Caplan: But there is access to the medical records for the purpose of auditing and quality assurance.

Ms Watts: There needs to be if you wish to audit the recording.

Hon Mrs Caplan: There is no requirement right now for advance consent?

Ms Watts: From a specific patient? No.

The Chairman: Thank you very much for your presentation. You have been most helpful and I thank you for taking the time to come before us.

Mrs Jensen: As I said in the beginning, I would like some explicit messages in the legislation that is finalized. I think that is important.

The Chairman: We will be starting our clause-by-clause review of this bill on 28 August.

Our next presentation is from the Ontario Nurses' Association. Representing the Ontario Nurses' Association we have Noelle Andrews, assistant director, government relations; Arlene Babad, nursing practice officer; Pat Bethune, president; Glenna Cole Slattey, chief executive officer; and Seppo Nousiainen, research officer. I am doing the best I can with these names.

Welcome to the committee. I am not sure whether the same people whose names I read out are before me, so perhaps you could introduce yourselves once you begin. You have been given half an hour, and as you could see from the previous presentation, we would like you to leave some time for questions. We are running a bit over today, so we will try to keep it as close to the half-hour as we can.

#### ONTARIO NURSES' ASSOCIATION

Mrs Bethune: The people you did introduce are here: Seppo Nousiainen, our researcher, Arlene Babad, our nursing practice officer, Glenna

Cole Slattery, our chief executive officer, and Noelle Andrews, assistant director of government relations. I am Pat Bethune, the president.

Good morning and thank you for the opportunity to be here today. I am the president of the Ontario Nurses' Association, the largest independent trade union in North America. We represent 50,000 registered and graduate nurses out of the 80,000 total working in this province. As the voice of these professional staff nurses who work in hospitals, nursing homes, homes for the aged, public health units, the Victorian Order of Nurses, medical clinics and private industry, ONA brings a unique and knowledgeable perspective of health care to this committee.

Our union supports the expansion of community-based services by requiring that new facilities be established on the identified needs of the community. The act may improve the accessibility of these alternative types of health care services that are desperately needed within the community. There is certainly the possibility of some cost savings as medical procedures currently performed in a hospital setting could be shifted into the independent facility and performed on an outpatient basis. Now, however, I would like to review our union's main concern about the act.

We are concerned that there is a potential that these health care facilities could be opened up to privatization. This union is against the erosion of our health care system by a move to for-profit settings. Every taxpaying citizen has paid for and expects to get equal access to comprehensive, high-quality health service. Any possibility of the fundamental principle being jeopardized for the sake of the balance sheet cannot be tolerated. We do have some concerns about your definition of "nonprofit," and perhaps when we are finished we might get an explanation of that.

This union believes that it is time to encourage a system of payment for doctors with less emphasis on a fee-for-service basis, as contemplated in section 23 of the act, and perhaps towards a salaried system for doctors, for instance. The number of doctors' claims to OHIP has increased dramatically: between 1987 and 1988 there was a \$6-million jump in the fee-for-service claims.

We are concerned that the act limits the establishment and operation of independent health facilities to ones in which members of the public receive insured services. This means that only physicians and a select few other health care providers can establish these centres. Unfortunately, this excludes other practitioners and services, such as nursing centres, unless there is a physician involved. Now is the opportune time for Ontario to open the door to increased efficiency and quality of care by letting health care practitioners other than doctors establish an independent facility.

#### 1100

Study after study has proven that programs run by nurses can provide innovative and cost-saving health services for large segments of the population. Indeed, in many remote areas registered nurses are now the only full-time professionals available to a taxpayer seeking health services. For example, in Manitoba patients attending a hypertension clinic staffed by nurse practitioners were more successful in lowering blood pressure and losing weight than patients attending a clinic staffed by physicians. The obvious savings that these and many other studies document are ample incentive for provinces to broaden the scope for the involvement of nurses in the delivery of health care.



Comprehensive health care, of course, includes the specialized treatment only a physician can provide and the state-of-the-art diagnostic equipment only hospitals offer. However, as all the players have already acknowledged, there is only so much money for health care. To ensure that there will be enough to meet our future needs, we must now begin putting the structure in place to redirect part of our limited resources into more economical, and often more effective, home- and community-based care.

It is anticipated that these independent health facilities will perform such procedures as laser surgery, in vitro fertilization and cataract surgery, all potentially life-threatening procedures. Proper standards of operation must be developed for these procedures and with these standards must go a mechanism for government enforcement.

One of our main concerns is that if profit-making organizations are permitted to operate independent health facilities, the pressure to maximize revenue and minimize costs could lead to the "Close enough is good enough" theory of management: the letter of the law will be followed, but ways will be found to circumvent the intent. It is our union's experience that in these situations the minimums become the maximums. For example, nursing home regulations say that a nurse is to be available at all times. So what do the operators do? There is a nurse available, all right, but she is on call and at home.

We are also concerned that no standards of operation are incorporated into the act, leaving the government free to set whatever standards it deems to be satisfactory. This certainly could have an adverse effect on staff nurse/patient ratios in independent health facilities. Low staff nurse ratios equate to low or little care.

This union believes that the act should be amended to allow employees access to interest arbitration to settle their terms and conditions of employment. The Hospital Labour Disputes Arbitration Act contains no mention of independent health facilities, nor, for that matter, of community health centres or health service organizations. This means that the workforce in these agencies is not guaranteed access as Canadian citizens to the collective bargaining process, as are those nurses in acute care facilities presently.

Since nurses are viewed as essential services, we believe the right to arbitration is the only way to ensure that the owners of facilities do not try to save money by forcing employees out on strike or lockout. This is not an unusual situation. Public health units in this province have frequently locked out the community health nurses and diverted the money saved in salaries to other expenditures. Since these independent health facilities could also be set up by hospitals, there must be protection of the employees' rights under the collective agreement should they be transferred to these facilities.

This act should include some mechanism to deal with issues arising from excessive workload. There is no indication that the independent health facility will somehow be magically exempt from the current kinds of problems confronting staff nurses in existing facilities as related to forced overtime.

Based on this union's survey of provincial staff nurses in March 1988, nurses across Ontario are required to endure working conditions that greatly reduce the amount of direct care they can give to their patients. These conditions include too few support staff, excessive patient loads and poor work scheduling. In addition, nurses are spending an average of 30 per cent of their time on non-nursing tasks. These deplorable conditions, coupled with

other working life frustrations such as lack of recognition by their peers, poor employer support for extra education and little say in health care management, may well confront nurses working in independent health facilities. There must be a mechanism put in place to protect not only the staff nurses but also their patients.

In closing, this act has the potential to be the vanguard move to make the fundamental shift in the balance of our health care system from expensive, curative, institutionalized care to more cost-effective, community-based preventive programs and services. However, without the changes that we have discussed in our presentation this morning, there will be no significant structural shift in our provincial health care system. In fact, all the necessary ingredients for detrimental care at the community level appear to be inherent in this act as it now stands.

Thank you very much. Myself and the staff will be prepared to answer any questions.

Ms Cole Slattery: I would like to add to the president's remarks here, if it would be appropriate, based on the conversation you had with the previous group. I do not want to get bogged down in the small nuts and bolts of what I believe is a very broad philosophical approach the minister has put forward.

This is really a change in the system, and whether the door swings left or the door swings right or whether you have elevators or escalators is not really moot at this point. It will be at some point, but I do not believe it is here.

What we are really talking about is changing the way a service is provided, hopefully as good if not better service and, the bottom line is, in a more cost-effective way. I think there has to be some thought given to the government's obligation to do something about this spiral, because when you have one third of the public purse going out of one ministry, everybody wants to dance with you. Right, minister? Very popular.

Mr Reville: She is such a good dancer.

Ms Cole Slattery: She does not have to be a good dancer. She could have two left feet with one third of the public purse flowing through her ministry. You have to dance a lot, even if you do not want to, even if they step on your toes.

Years ago there was a very simplistic definition. What is the difference between a doctor and a nurse? It was quite simplistic, but it might lend itself a bit to the discussion at hand. A nurse observes and reports; a doctor diagnoses and prescribes.

Mr Jackson: And bills.

Ms Cole Slattery: Right, I was going to get to that. I was going to try to slip it in, but you have done the sledgehammer for me.

That is a very critical point for government to consider, because the "diagnose and report" has implicitly embodied within it a pathology: "This human being is sick." That is why there has to be a differential diagnosis made and some form of treatment established and set out upon.

What we are looking to do in this type of health care—It is not really health care; it is really sick care in disguise, because what we have now is the doc guarding the gate, and you cannot get in without the doc and you cannot get out without him.

Identifying the pathology and treating it is the old way. But if you look at what a nurse does, which is observe and report, I believe that could be fed down into just the types of services you are thinking about, because this whole movement towards health—I will take the Honourable Mrs Smith; she is really too young. In our day, who ever heard of B-12 and all those good things?

Interjection.

Ms Cole Slattery: I said you were too young.

Mrs E. J. Smith: I accept the definition.

Interjection: I remember all those vitamins, the cereals, the brans. I mean, the whole population is —

Hon Mrs Caplan: I remember that.

Ms Cole Slattery: It is all gone to disease prevention, which in many ways has an educational component in it. You have to teach people how to do these things and why they should do them.

Having said that, you lead directly down into monitoring. If the patient is out of the hospital and back in the home, the nurse's responsibility then is to monitor this patient and provide an early referral service if indeed the patient's condition deteriorates and the physician is needed again.

Having said, in these very broad philosophical definitions of doctors and nurses as they relates to what the minister is trying to do with the industry, you would be foolish in the extreme not to give some serious thought, certainly through definition, I suggest through funding, through the insurance acts or whatever you would have to look at—I submit that this would be a very fine time to give some consideration to third-party reimbursement to registered nurses.

You have communities, especially in the north, where the only health care provider in the entire township is a registered nurse. There are instances up north where we worked in remote areas, where this—God love her, not that she would ever be that foolish—fine young woman who is about ready to deliver this child says: "I have to get on the phone and call the doc back, wherever he happens to be, because I am going to be doing this delivery via the telephone, really."

1110

Those things are in existence now, so why not legitimize them? Why not fund them? You could cut the province into five regions and do a series of regional pilot projects before you put it on the books and make it for ever and ever, amen. It is the old joke: Moses said, "These are the laws, and the mountain over there are the rules." You get yourself all involved in some of this stuff and end up with more cost and duplication of services. You could do pilot projects like this right in downtown Toronto. It would not necessarily have to be in Rankin Inlet or wherever.

Hon Mrs Caplan: This act is permissive.

Ms Cole Slattery: I know, but I am urging you to permit.

Hon Mrs Caplan: Oh, I see.

Ms Cole Slattery: I am trying to give you reasons why. Let's talk about who will come and sit in front of you and object to this. The Ontario Hospital Association will. God forbid; we might have fewer acutely sick people. You have to think in terms of people protecting their own bums, do you not? The docs will object. They will say: "No, no. These women will be practising medicine without a licence." They are heavy hitters. They do not sleep all the time. You have detail people. You have pharmaceutical people. You have salesmen. A lot of people will object to this because it will render a more simplistic service.

But the bottom line is what you are talking about. You are not talking about making widgets; you are talking about providing health service in such a way that they are health maintenance, disease prevention and an adjunct as you sit and speak to acute care. But you all look and sound to me like you want health to be more the norm and acute pathology less the norm when it comes to funding. I am well aware that the Globe and Mail does misquote from time to time, but basically that is what it has been putting out.

What can we do to help you? We believe we have the manpower, overeducated, overworked and underutilized. We believe our constituency, our 50,000, is ready, willing and able. We would suggest that if it is politically sensitive and you just cannot make great sweeping changes—When I first heard the phrase "muddling through" I was appalled, but there is some merit in incrementalism. It prevents major mistakes at the onset.

Even if you could politically, with a small p, think in terms of regional problems, we would be delighted to give whatever it is that we would have that would support a pilot project. Arlene made mention of a problem: If you would look kindly upon what we have said and would among yourselves decide to pursue it even in a limited way or in a pilot project way, Arlene needs to point out to you that as the health professions legislation review sits now, you cannot.

Ms Babad: I was listening to the discussion previously. There was a lot of mention made about the health professions legislation review, and that although it governed professionals it was raised in the context that it would facilitate the establishment of centres such as community health centres that could be run by nonmedical practitioners such as nurses. Well, I do not think that that is the case, in the sense that the proposed health professions legislation review limits the role of nurses, because all the licensed acts cannot be performed without the order of a qualified practitioner such as a physician or a dentist. So if you did establish that type of centre that would be run or mainly comprised of nonmedical practitioners, including nurses, their role would be limited by the proposed health professions legislation review as it currently stands.

Hon Mrs Caplan: The point I made was that the issues of scope of practice and the issues of the HPLR are under discussion right now, and they really do not have today any implicit policy approval, so it is premature at this time to discuss that in this context, but this act is permissive to—

Ms Cole Slattery: Except that, in its permitting, if you went



forward you might be forestalled by the health professions legislation review if it were moved in the form in which it now sits.

The Chairman: We have some committee members who wish to ask questions, beginning with Mr Jackson.

Mr Jackson: I am not surprised but very much concerned that three groups now in the last 24 hours—The Ontario Women's Action Coalition yesterday said we should table Bill 147 pending completion of the health professions legislation review and related legislative proposals and a clarification on the most effective division of labour among health care professionals in community-based facilities. Earlier, in the presentation by the Registered Nurses' Association of Ontario, it stated, "It is our opinion that the act should be redrafted." Now we hear you suggest that the act has all the ingredients for detrimental care at the community level unless there are modifications made.

In and of itself, those major groups coming forward, this government should be taking a very strong review of the direction.

My concern, and it is the concern I raised the first day when we were briefed, is that we are not seeing all the pieces of the puzzle. I understand your point about incrementalism, and that is understandable; the minister has an agenda and just so much legislative time. However, I cannot see how we are going to get a sense of the vision of where health care is moving in each of the component parts of its agenda, and one of the agenda items is the division of labour. Let's face it, that is a women's issue.

Ms Cole Slattery: Absolutely. This industry has an 80 per cent female work force.

Mr Jackson: Exactly, and thanks to you and your organization and your persistent beating on the doors of all of our caucuses, you have allowed us to reorient our thinking and understanding of this issue, and you have gained some support among various members of all three political parties in terms of understanding your agenda.

However, for the life of me, I cannot understand how after the division-of-labour issue was made so prominent and where it was centred on the arena of a hospital, where it took you three decades just to get equal representation on hospital committees—And anybody who has sat in on an hospital meeting will know what a glorified boys' club hospital boards are.

Ms Cole Slattery: Real locker rooms.

Mr Jackson: Virtually all of them, from what I have seen, and I try to meet as many as I can.

But at the very time you make some progress in that area, we now have a piece of legislation that moves the venue out into the community. The reason I am trying to demonstrate this is to get a general image of what is concerning me.

The Chairman: You are getting to a question?

Mr Jackson: I practised restraint at the front end of this morning and I suspect that you will be patient with me as I take equal time.

The Chairman: I am patient.

Mr Jackson: Thank you, Mr Chairman.

Now, with the advent of a new assistant deputy minister from Manitoba with NDP training and an understanding of the division of labour—he is in place—all of a sudden they change the rules of the game. That was not necessarily a designed play from the cabinet bench. I think this legislation is proceeding for entirely different reasons. Still, that is an effect you have to deal with, and that is why you very well put forward the issue of arbitration and all those matters; they are labour matters, let's face it.

But I see a tremendous increase in the vulnerability of a whole group of health care deliverers as a result of this. It does not mean the legislation is bad; it just means it has to be fixed. To that extent, you are the first one to put a really fine point on it and I wanted you to know that. I do not know how we are going to deal with it, but somehow we are going to have to deal with it.

I want to ask you generally, Glenna, if your concern is that in the absence of the three pieces of legislation, front and centre, discussed and looked at: the health professions review; the district health council legislation, because they can be glorified hospital boards in and of themselves unless we guarantee—

Hon Mrs Caplan: There is no legislative intent.

1120

Mr Jackson: I know there is not; it is at the discussion level. But if the district health councils are going to increase their autonomy and power in terms of deciding what is happening in the community, I want to make sure they are not operating the way hospital boards have operated for the last three decades. All three pieces of legislation are relevant in terms of deciding where we are moving.

I would like you to comment in both those areas I have raised in terms of the shifting venue for the agenda and also in terms of the need to understand clearly from this government, or to consult with the three pieces of legislation simultaneously so we do not get into a corner with some of this stuff.

Ms Cole Slattery: You are exactly right, although I would suggest that there are four pieces of legislation that would bear upon this, the fourth piece being the opening of the Public Hospitals Act. None of these focuses or points of discussion or points of reference stand in and of themselves. They all impact very heavily. Having read the front page of Hospital News last week, when there was a picture of the Ontario Hospital Association hierarchy and what have you, and in which the lead article dealt with reimbursement vis-à-vis case mix, I would submit that what we are really looking at here in disguise could possibly be—I am not going to second-guess the government, but I have been in this industry for 40 years and there is very little now that I see that is not coming around for at least the third time. The women know broad shoulders were in in the 1940s with Joan Crawford, right? These philosophies are cyclical.

I wrote my master's thesis on the diagnostic-related groupings, and if the three issues you mentioned plus the Public Hospitals Act are all geared

towards some type of retrospective reimbursement as it relates to the diagnostic-related groupings mechanisms, in which funding is conducted in the United States, I would submit—do not believe me; I can get lots of docs and hospital administrators who will come and tell you—that if you want chaos and second-class medicine for third-party pay, that is the way to do it.

That is why I started out with "a third of the public purse." The government is in a very difficult position. It did not go to a third of the public purse since Mr Peterson took office. It has been going in North America for the last 10 or 15 years, and everybody thinks at every point that they have it stopped but it slips away from them again. So I would suspect that all of what we are talking about has something, if not everything, to do with funding.

My contention is that the Ontario government funds the health care system handsomely. There is something wrong when you have to take more than 30 cents out of every tax dollar for one ministry. Having said that, I think the problem is that the whole industry, from my perspective anyway, is totally mismanaged. It is a bunch of widget-makers running hospitals; it is not a profit-loss balance sheet.

You are very right. We are keenly interested in district health councils. The assistant director of government relations deals with a province-wide elected legislative committee for the union and our marching orders are: "Get on those health councils. That's where the action's going to be." We are well aware that everything you say is true in that it does intermesh, but I believe it is all resting upon the head of the pin of the dollar.

Mr Jackson: I do not think so. I do not agree with you on that. I think we are in a process of dealing with the politics of health care as well.

Ms Cole Slattery: Absolutely.

Mr Jackson: The politics are: I see some significant amendments in this legislation from the time it was first announced, which is a capitulation in some quarters to certain groups, before we even got to this stage. But I will leave that.

I just wanted to serve notice with a question. Could we get a response from the minister or staff, not at this moment, on the issue raised by the ONA with respect to its labour position with independent health facilities? In a hospital environment, there are certain dispute resolution and grievance opportunities. All of that is available to them. To what extent does the legislation speak to that issue or will the regulations speak to that issue in terms of moving them from a hospital environment into a clinic environment, and do they abdicate and walk away from those rights by changing the venue? I think it is a valid question. It has not been raised previously. Could we get some clarity on that, whenever it is convenient?

The Chairman: Okay.

Mr Jackson: Thank you.

Ms Cole Slattery: And you know, Minister, it is not as far afield as you might believe, because if the object is to go into teaching, early detection referral, etc, then there will be less use of some acute care facilities. The building is already available. What are they going to do: go

two blocks down the street and build another building? They are going to utilize those operational facilities already in existence, and considering that nurses are not really an embarrassment of riches at this point in time, they will no doubt have to transfer staff. When they transfer her over there, where is her collective agreement?

Hon Mrs Caplan: We will check the implications for right or wrong.

Ms Cole Slattery: Absolutely. It is not complicated. It is just putting these into the definition of a health care facility. In my mind, there are more health care facilities than the existing hospitals that are sick care facilities. It would be just a matter of inserting these facilities, if and when they are ever formed, as applicable under the definitions of facilities in there.

The Chairman: We have three other members who wish to ask questions. The point has been raised and we will get back to it.

Mr Reville: As always, it is an excellent submission from the Ontario Nurses' Association. One of the things that the minister has assured the committee is that hospitals will be able to participate in this approach. I suspect many will. That should worry you. It worries me. I know you have been having a hell of a time trying to get hospitals to grant you the say in hospital affairs that the minister promised and regulations were changed, but the hospitals do not seem to have changed.

Ms Cole Slattery: We have one hospital.

Mr Reville: One out of 223, not bad. I have a letter today from Locál 94. They are having the same trouble at Wellesley Hospital that we have had elsewhere. I do not know why it would be any different in an independent health facility for you.

Ms Cole Slattery: It will not be.

Mr Reville: That is a major concern. Members of the committee may know that in the Public Hospitals Act, the regulations were changed to allow nursing input into the key decisions. This was the minister's effort to try to improve the situation in nursing. It is just not happening. That is a problem.

Ms Cole Slattery: It was regulated in February of this year.

The Chairman: Can we ask which hospital?

Ms Cole Slattery: Queensway General Hospital. It was very fine. They took the suggestions we submitted to the minister on how it would flow, and it was a very fine response from Queensway General Hospital.

Mrs Bethune: They are in the process of setting up nominating committees and actually holding the elections, and they hope to be ready to go by your 30 September deadline.

Mr Jackson: My hospital says it has not received the regulations yet.

Mr Reville: That is possible.

Ms Cole Slattery: We have 97,000 extra copies, so I can correct that quickly, this afternoon.



Mr Reville: You might want to take the Queensway General experience and use it as a model to kind of guilt the other hospitals into playing.

Ms Cole Slattery: Listen, we are so busy with our guilt bucket now that it is almost empty. I will have to wait till it wells up.

Mr Reville: It is amazing, though, that the flagship hospitals of this province are being so reactionary.

Ms Cole Slattery: They are the ones that are most entrenched. Listen, let's talk about what we are talking about.

Mr Reville: Let's talk about what we are talking about.

Ms Cole Slattery: Can we talk? We are talking about an industry that takes one third of the public purse, which is 80 per cent female. My group is the largest single group within it, which is 98 per cent female. We are being bogged left, right and centre.

I feel sorry for a seated government. You brought down pay equity. Forget it. It is going to cost us a quarter of a million dollars this year to get nothing under your law. You changed the hospital rates and I was grateful. I made that gratitude known. We were jubilant. That was in February. Well, I ain't so jubilant now, but God love you, you did the best you could.

Pensions: the government brought down pensions for part-timers. Half my membership is part-timers and the Ontario Hospital Association will not implement the law, because the law says "eligible for." Is your definition of "eligible" mandatory? It is not mine. We have no pensions, and they were eligible January 1988 or whatever. Here is an instance where this government has brought forward and legislated initiatives which our membership should reap and we still have nothing, because it is a sexist, feminist issue. The administration of hospitals are the last of the great Neanderthals. They all believe in manifest destiny, you know, the white man's burden to lead the world. They resent us; they call us litigious because we take them to court to get them to implement the law. That is not litigious, that is an honest citizen. In this whole morass, unfortunately, you are looking at a women's issue that is, from our standpoint anyway, totally explosive. How unfortunate, because the statutory requirements are there.

1130

Mr Reville: Glenna, I was hoping you would not mince words.

Ms Cole Slattery: I did not. I like to be laid-back and soft when I get into these things.

Mr Reville: What you are saying is that the pay equity legislation does not work. Those regulations have not made the changes you hoped they would make. I think you are being too easy on the minister. She could make it happen if she wanted to.

Ms Cole Slattery: Pensions for part-timers: hey, listen, she is only one person.

Mr Reville: But she is in charge of the whole schmeer.

Ms Cole Slattery: She is not writing job descriptions for the Ontario Hospitals Association yet. Maybe she should.

Mr Reville: But I tell you, if she told the OHA she wanted it this way or, that way, it would be this way or that way; do not kid yourself.

Ms Cole Slattery: Anyway, I would like it if the government was named as the employer and we would be done with all this.

Interjections.

The Chairman: Order, please.

Mr Carrothers: I do not know how much time we have left, Mr Chairman. I just wanted to ask two brief questions.

The Chairman: We are over time, Mr Carrothers.

Mr Carrothers: We are over time by a great amount, I guess.

On the bottom of page 3 of your presentation, I guess in dealing with the issue of changing the focus of our health care system and alternatives to the present way services are delivered, you mentioned the question of insured services. I guess this may be just a reiteration of a comment I made for the last group. It sure seems to me that this legislation is not the be-all and end-all of these changes; it is really only a small part. It starts us down the road. Really what it is talking about is a facility and funding the operating costs.

Hon Mrs Caplan: Yes.

Mr Carrothers: Until we get changes in what is an insured service, the third party pay you were mentioning, and what will be recognized to be paid, that is where the real change is going to have to be made. It really lies outside this legislation, I think, and I am not sure we can change this legislation to impact on that. It is part of another series of reviews and other changes would need to be made. I will just make that as a comment. I do not think we need to reiterate that.

At the bottom of page 5, though, you have talked about something, and I am wondering if you have identified a loophole. You were talking about extra-billing and you were talking about a regulation that could be made prescribing the services for which a facility fee could be charged. I picked up my copy of the legislation. What I have is the one with the amendments proposed to be made, so it is different from the one tabled before the House. I do not see that there. I am wondering if you have a specific reference or if this has been amended. I guess that is the part I want to get at. Maybe this has been amended already and this problem is not in the legislation any more.

Mr Nousiainen: In the minister's proposed amendments, is that the legislation you are talking about or the early stuff?

Mr Carrothers: What I have is what we are using before the committee, which is a copy of the bill with amendments which the minister intends to propose worked into it, which means certain pieces of the old bill are out.

Mr Nousiainen: That is right, they are out. They were in the original.

Mr Carrothers: This section you are talking about is now gone, then? Is that why I cannot find it?

Mr Nousiainen: Yes, that is right.

Mr Carrothers: That answers my question, so I will not worry about it any more.

Ms Cole Slaterry: We had this all prepared for you early in the summer, figuring you would move expeditiously.

Mr Carrothers: I think we moved as expeditiously as it often moves around this place, which means we did get to it this year.

The Chairman: Final question, Mrs Smith.

Mrs E. J. Smith: I wanted to thank you for a most spirited presentation and I want to concur with you that this is very much a women's issue. I wanted to say to you that I think it is so for two reasons: because women are providing it, but also because across this province almost all women have been in hospitals—

Ms Cole Slaterry: Absolutely.

Mrs E. J. Smith: —whereas not all men have. Therefore, they well understand the division, not only of labour but I think what has to be recognized throughout the province is the division of responsibility and the stress of responsibility.

Ms Cole Slaterry: Absolutely.

Mrs E. J. Smith: I hope as an association you are reaching out to this broad base of women in your crusade.

Ms Cole Slaterry: We are organizing them as fast as we can, ma'am.

Mrs E. J. Smith: The comment, then, on that in response to your very spirited presentation is that your definition of nurses versus hospitals, I thought, left out a middle word, speaking as a recipient and not as a giver of service. You speak about diagnosis, prescription, observation, report, and there are the very important words "caring for."

Ms Cole Slaterry: Absolutely.

Mrs E. J. Smith: That is where nurses are, and that is the word that, added in, will make use of these independent health facilities, I hope, because we have a tool to move to prevention and health care. I hope you manage to look at your definition as you spread the gospel of what women are doing.

Ms Cole Slaterry: The care givers care for themselves a little bit now, which is causing no end of friction for us with a variety of people. I hear what you are saying and I agree with you, but it is very hard to legislate that focus.

Mrs E. J. Smith: That is right. As a receiver of health care, I understand very much that role.

The Chairman: Thank you very much for your presentation and for taking the time to come before us.

Our next presentation is from the Ontario Coalition for Abortion Clinics. Representing this organization are Ms Nanci Harris and Ms Cherie MacDonald. Perhaps they will come forward.

We would like to move along. Welcome to the committee, what is left of it. You have half an hour for your presentation. Hopefully, that should include some time for questions from members of the committee. You may proceed.

#### ONTARIO COALITION FOR ABORTION CLINICS

Ms Harris: My name is Nanci Harris and I am speaking as a representative of the Ontario Coalition for Abortion Clinics. To my left is Cherie MacDonald, who is the official spokesperson for the coalition.

What I would like to read to you right now, which I believe you were given a copy of beforehand, is the executive summary and recommendations of our brief concerning Bill 147 and the impact that Bill 147 would have on women's reproductive health care. After reading the brief, I will be open to questions, as will Cherie.

On 28 January 1988, the Supreme Court ruled that the existing abortion law was inequitable and unfair to women. Here in Ontario, the 1987 Powell report had already demonstrated the shocking inequality of access to abortion and the poor quality of care in many hospitals.

For years the provincial government had been saying that its hands were tied by the federal law in dealing with this crisis. That constraint has been gone for over a year. Ontario now has the opportunity and the responsibility to ensure that all women have access to the best possible abortion and reproductive health care. Hopefully, this legislation indicates that the province is moving in the right direction to meet this challenge—community-based reproductive health care.

The advantages of community clinics have been demonstrated for years. They have the potential to provide abortion, childbirth and other reproductive care that is as safe as or safer than hospitals, more accessible and more cost-effective. Because workers in such clinics are committed to women's freedom of choice, they provide a more sympathetic and supportive environment.

The starting point for any legislation on independent health facilities must be a clear sense of public priorities and goals. The Ontario Coalition for Abortion Clinics believes very strongly there are four fundamental principles that must guide the development of any community-based reproductive health care legislation. We recommend that the government adopt the following four goals as the guiding principles of reproductive health care: (1) comprehensive care for the full range of women's reproductive health needs; (2) equal access to required care throughout the province; (3) informed choice and (4) responsiveness and accountability to community needs.

#### 1140

Women in Ontario face many systemic barriers to access to abortion in their own communities. Unfortunately, neither the provisions of Bill 147 nor the minister's statements indicate how these barriers will be eliminated.

First of all, we recommend that the provincial government make a clear commitment to ensuring that every woman has free and equal access to high-quality reproductive care, including abortion, in her own community. The



means to accomplish this goal is a network of publicly funded clinics working in whatever language women need and providing abortion services and counselling. As soon as possible, these women's reproductive health centres must begin to offer the full range of reproductive care, from safe and effective contraception to abortion, from birthing and midwifery to well-woman and well-baby care and from sexuality counselling to reproductive technology, developed according to women's needs and priorities.

This brief outlines a model of how such women's reproductive health centres could work to ensure comprehensive care, equal access, informed choice and responsiveness to community needs throughout the province. What you were just handed is the actual brief we have.

The Independent Health Facilities Act does not address at all the issue of unequal access to abortion. The government might request proposals for community clinics, it might ask district health councils to assess local needs and solicit proposals and it might approve some of these proposals, but the provincial government has made no commitment to establish the required facilities or to allocate sufficient resources to ensure that every woman has prompt and free access to the highest-quality reproductive health care in her own community.

We realize that legislation cannot specify funding levels, but the minister certainly can. We recommend that the minister make a clear commitment that sufficient funding will be available to create and sustain a network of women's reproductive health centres throughout the province and ensure that each is able to offer the full range of free comprehensive services.

The grandfathering provisions of Bill 147 are far too restrictive. It is unacceptable that existing independent abortion clinics, such as Choice in Health and other birthing and reproductive health centres soon to be opened, may not be covered. We recommend that all community reproductive health clinics established at the time any legislation on independent health facilities is given royal assent should be licensed subject to endorsement by their local district health council.

It is equally unacceptable that the government's failure to quickly bring the existing abortion clinics into the public health system has meant that thousands of women have had to pay for an essential health service. We recommend that the Ministry of Health fully reimburse the fees paid by all women who have had abortions at independent clinics in Ontario from the time of first reading of Bill 147 to the date on which any legislation on independent health facilities is given royal assent.

The funding and licensing provisions of Bill 147 are so vague and cumbersome that they can only hinder the development of community centres. The government must be willing to provide seed money for community groups to explore how best to meet the specific needs of their community. The approval and funding process must facilitate proposals coming up from the grass roots, not only through the district health councils.

A further glaring weakness in the bill, and one that will increase existing barriers to equal access, is the fact that commercial health care will be allowed. The history of child care, care for the elderly and other services in this province and elsewhere illustrates the contradictions of commercial provision. The imperatives of profit and investment can lead to limited access for those unable to pay, lower-quality care and significant regional inequality and service. We have also seen that it is totally ineffective to merely prefer nonprofit and Canadian operators.

We recommend that any legislation on independent health facilities explicitly state that only nonprofit community-based health centres will be licensed and funded. We agree with the Minister of Health that abortion care must be provided in the context of other comprehensive services, including sympathetic pre- and post-abortion counselling as well as birth control and sexuality counselling. There is no reason why many existing community health centres cannot provide these services at once. As soon as possible, the range of care must be extended, especially to include midwifery and childbirth.

Our brief details a framework within which women's reproductive health centres could provide such comprehensive care. The values and ethos that underlie such comprehensive care and the precise mix of services cannot be specified in legislation, but the minister can make the government's philosophy and principles clear.

We recommend that the Ministry of Health develop a policy paper on how comprehensive care for abortion can be provided. This paper should address the model of women's reproductive health centres that we outline here.

Community-based care means more than simply being located out of a hospital. It means being accountable to a particular community and responsive to its particular configuration of needs. There is no mechanism for such accountability in Bill 147.

We recommend that any legislation on independent health facilities require that every facility have a community board whose membership must be truly representative of the diversity of the local community. Critics of government policy are often accused of not offering positive alternatives. The bulk of our brief is a detailed model of how women's reproductive health centres could actually work. We also set out a timetable by which the government can move to establish a network of women's reproductive health centres throughout the province.

We recommend that within two years the government must facilitate proposals and initiate the development of a community reproductive health centre in each region. Within five years the government must ensure that there is at least one women's reproductive health centre offering the full range of reproductive care, from abortion to midwifery, in every district health council in the province.

We started by saying that any legislation on independent health facilities must meet the goals of comprehensive care, equal access, informed choice and responsiveness to community needs. Bill 147, even with its proposed amendments, dramatically fails to do this. We recommend that Bill 147 be withdrawn and its provisions and intent totally revamped.

Ms Hosek: I very much appreciate the comprehensive way you have looked at this question. Let me just ask another question about comprehensiveness. The way you have chosen to situate this whole question is to ask the government to make sure there are comprehensive reproductive health services for women across the province. But I think one of the directions the government has taken is a little more comprehensive than that; that is to try to increase the number of services for the health needs of women that are broader than merely reproductive ones, partly, I guess, on the theory that women are whole persons and their reproductive systems are not unconnected to all the other issues of their care. There are forms of concern that women have for health other than reproductive issues.

Would you be as comfortable with the notion that the government should be using this legislation, as well as the other kinds of legislative review we are doing, the other kinds of legislative work we are doing, to increase the number of comprehensive centres that fund a range of women's health issues? In other words, there are issues having to do with thermography, osteoporosis, stress and lots of other kinds of health issues that are particularly women's issues. Would your proposal stand in the same way if the strategy were to be a somewhat broader one, in a more comprehensive provision of health care to women?

Ms Harris: I think only if there was a clear commitment on the part of the minister and the government to ensure that the full range of reproductive health services is mandatory, that all women in Ontario have a right to them, that they have a right to full access and that these would not be submerged or fragmented in an effort to provide this wonderful global centre that would be doing little bits for everyone and not a full extensive range of reproductive health care services.

Ms Hosek: I think I understand the statement you are making about the needs for all kinds of reproductive services, the broadening range of it. I have to say that I do see this legislation as enabling legislation, as legislation that will allow not only for response from district health councils but also for the minister to decide that certain kinds of services which are not available in certain communities or in certain regions should indeed be made available and to call for proposals for them. So it is not simply a response to what district health councils decide is important in a region that is going to be running this legislation. I believe that one of things the legislation is meant to do is to enhance accessibility, because you pointed out that there have been some numbers of women who have had to pay facility fees for abortions performed in the past number of months and in fact for the past number of years.

Despite your critique of the bill as a whole, do you approve of the way the bill is trying to deal with accessibility when it is connected to financial resources; in other words, its attempt to make sure that if women do indeed have abortions in out-of-hospital facilities they do not have to pay a facility fee or any fee at all? Is that something you support?

1150

Ms Harris: In so far as women would have free and full access, absolutely. But the problem with the legislation is that nowhere is it written in anything other than conceptual terms that there will be a commitment to equal access. It talks about it, but it does not say how. There is not a clear promise to do that.

The other concern we have is that because there is no commitment to capital funding, community groups who may have some extremely good ideas and local resources find it very difficult to mobilize, to be able to put together a needs assessment or to be familiar with how to approach a district health council or to appear in such a way that is favoured by the council.

Lastly, our other concern is just the opposite: that allowing a minister that much power to grant licences and to be able to have the final say puts us in severe jeopardy if, for example, the unthinkable happens and an anti-choice person is put in as the Minister of Health, because then his very personal beliefs could possibly overflow into his professional capacity and we could be in severe jeopardy again.



Ms Hosek: How would you make sure that did not happen, given that the legislation is not about specific procedures; it is about enabling certain kinds of facilities to exist in the province with a variety of different health care needs met by them?

Ms Harris: First, the government has to make a clear statement, which OCAC has been calling upon for the last several weeks in many of our demonstrations, and say loud and strong, across Canada as well as Ontario, that abortion is a legal service that should be available to all women and that they have the right to have full and free access to it.

So having said that and that being entrenched in law so that clearly there cannot be any more attempts to overturn it, then we could get on with the business of setting up clinics and not dealing with specific services, because that would already be there; that would already be stated. But we get so lost in the entanglement concerning the issue of whether there should be a new law or not that the issue of how the clinics would provide a specific service such as abortion is not clear.

The Chairman: Could you help me understand a bit more about your coalition? How many Ontario citizens do you represent and are they scattered across the whole province?

Ms MacDonald: I could deal with that. Our membership is flexible in terms of how you define it, because a number of major organizations are members of the coalition, send representatives to our decision-making meetings from time to time, distribute our educational materials and have us as speakers. Those would include organizations like the Ontario Federation of Labour. So if you look at our organizational membership, it is very broad.

If you look at it in terms of our day-to-day activist membership, then we are talking a little over 2,000 and they are throughout Ontario. The day-to-day activist membership is at this time a large number in Toronto, but we are also seeing people now who are becoming activist with us in regions like Hamilton, Ottawa and the Kingston area. So it kind of depends on how you define the membership, but a very broad segment of the society does have some input into our decision-making and does get educational material from us.

Mrs Cunningham: Thank you for a very articulate presentation. I think your suggestions and observations about the preparation of proposals are interesting in that you are up against very stiff competition. I have looked at three or four proposals today that are going directly to the minister, and the proposals have been put together by hospitals for these kinds of services. Although they have been called for independently, the approach is the same; very sophisticated.

On that note, I will say that many groups have told me they have hired people full-time under the guise of delivering health to write proposals and to lobby the ministry, and they have been doing that for some number of years, which I think is a total waste of the taxpayers' money, especially when we think those dollars are going to health care, but that is the position community groups are in. You do not have the money, so I very much appreciate your point.

Right now you may want some assistance in preparing a proposal. The district health councils have been supportive in different ways across the province and I am aware of how some of them have operated. I think they are now finding themselves in a bit of a conflict here, because I think they are



more than willing to assist your group in getting the needs assessment done and helping you in some way, sharing with you information, opening a few doors, giving you lists and what not. At the same time, that same district health council is going to have to be in a position to choose between the health board that comes in and offers this kind of support you are providing to the community and perhaps yourselves, who may in fact have in your opinion a board of directors, because I notice one of your recommendations was at the community board. Even in these other proposals people run around and get boards for their proposals, and you can imagine who they are.

So from a grass-roots point of view, you are going to be in pretty stiff competition with others who are presenting more sophisticated proposals, from some of the same people who are sitting on hospital boards, let's face it. I am just wondering how you look at yourselves, given that dilemma, and how the district health councils will advise us as well about their concerns, because the role they have been playing is helping the public nonprofit groups prepare proposals.

This is all happening; it is not new. Many of us have been involved. I have been involved since 1976 in making proposals to the district health council in London. It sounds new, but it is not.

The Chairman: I am not sure there is a question there. Do you have a comment or reactions?

Mrs Cunningham: I am wondering how the dilemma—

Ms Harris: I would not say we have spent a lot of time trying to anticipate worries about how it will happen. Our concern, first, is that the government recognize that the bill in its current intent is unworkable. One of the things we feel very strongly about is that we have put our money where our mouth is. We have not just come and spouted rhetoric about what we feel are the needs of women; we have gone much further and provided you with a working, detailed framework which the government itself could adopt for the inception of reproductive health centres.

At the same time, this brief would also be available to any local group anywhere in the province. If, for example, they have determined there is a glaring lack and inequality of services in their region, then they could take the brief—they would not have to do all the work—use the resources they might not otherwise have and could then focus their energies, limited as they may be, on going head to head with the big guns.

I think there is recognition, though, that hospitals need to stay in hospitals. As you know, the evidence espoused in the Podborski report is that there is a recognized need and that community service and community clinics are the wave of the future. So going out into the community where the grass roots are, and where they have an intimate knowledge of the community and what is needed, seems to me more appropriate for the government to recognize as the way to go, rather than rely on big hospitals, which in effect are not available up in the northern and less populated regions.

Mrs Cunningham: Having said that, there are two questions. Hospitals have made it known in many communities that they do want to reach out into the community. We will be hearing from them around the very services, quite frankly, a couple of them that you are talking about. So I was just giving you the example of a community-based group versus a more sophisticated group that has been in the business for some time in some of the hospitals; not in the

same format you have, but in others. In all fairness, they have said, "This is exactly what we want to do and we'll be before your committee to tell you how we can do it."

Now back to the other point we were making. I think what you are saying—it is a very important point and I appreciate it very much; this kind of planning does not often go on in governments for these kinds of commitments—the time frame you have provided by which you say a women's clinic of the type you have described should be the goal of every health council across the province of Ontario; in a sense there would be some pre-empting around priorities if the government were to make that statement, and that is your bottom line, is it not?

Ms Harris: Yes.

Mrs Cunningham: That is great.

Mr Reville: I think the model you have offered is particularly important. It would be really neat if the government would make the kind of commitment you seek. I am sorry the minister is not able to be with us. Perhaps I understand why she is not, but I am sorry.

Ms Hosek has suggested that this legislation is enabling. It could as easily be disabling. I think it is your concern that the day this bill passes, Dr Nikki Colodny's operation gets shut down, and one year from that date Morgentaler and Scott could get shut down as well.

Ms Harris: That is correct.

Mr Reville: Ms Hosek has suggested the government has made strides in providing comprehensive women's health care. I dispute that. There have been some initiatives, some of which do not include abortion services. In fact, the services your coalition is interested in have all been provided without any government assistance, because the government refused to act. Every one of them is initiated by people not connected with the government.

1200

I have to take exception to Ms Cunningham, because there is nothing more sophisticated than the kind of abortion services provided by your members, anywhere. In fact, the assistance the clinics have been in developing standards of care in terms of abortion services represents the only standards of care we have in our whole health care system. You perhaps did not know that, but Scott, Morgentaler and Colodny have done that. The work of your group is very sophisticated indeed.

Mrs Cunningham: I agree with what you have just said. I was talking about writing proposals.

Mr Reville: The problem you are giving me is that you are asking for a clear commitment from the government, and I think we need it in the legislation. Unless it is mandated, you will get all the commitments you want and they will not be worth a damn. In fact, what the minister has been doing is dancing around this and refusing to make a clear commitment, saying, "We're going to offer comprehensive health care, period." Clearly, that is not good enough and I hope you will not sit still for that.

Ms Harris: No. I thank you for pointing that out, because I certainly did not mean to give the impression that OCAC only wanted clear

verbal or written commitments from the government. We want to see the minister make a commitment, because it is only within her realm that she can state certain priorities and directions; but then our expectation would be that those statements would be clearly captured within some form of legislation. As we said at the beginning of our brief, we believe fervently that any legislation which governs women's reproductive health care needs to embody four principles: comprehensive access, informed choice, equal access and community accountability.

Mr Reville: That is the other problem: Nothing in this legislation addresses the problem of accountability. The minister has indicated that she will not accept any amendments that deal with the question of accountability, responsibility, responsiveness and representativeness. In my view, that makes all the talk about community care so much hot air. Unless you have those mechanisms mandated, you do not get them. You get some joker operating a surgery with no connection to the community at all.

Will you take a look at your principles and give us some advice on how you might actually write that into legislation? You have until 28 August, when we are going to be doing that. I would be quite happy to move those amendments. I am just not quite sure how to do it. If you want to consult your lawyers, that would be very helpful. I think those principles have to be in the bill or you are going to lose out. I do not want to be alarmist, but I think that is clearly the direction it is going.

The Chairman: Thank you very much for coming before the committee.

Mrs Cunningham: Mr Chairman, for the record, before the coalition leaves, Mr Reville and I are on the same wavelength and I just want to make it very clear to the groups. I am extremely aware of their sophistication in the provision of services, in many instances the only services across Ontario. I am very appreciative of that.

When I was talking about sophistication, I am a community-based person and I know what kind of competition we are up against when you have full-time people writing proposals to the government, as opposed to the coalition, which does not have somebody on staff writing full-time proposals across the community. So the level of sophistication I was talking about had nothing to do with the delivery of services and only to do with the writing of proposals. I think you would agree with me on that.

The Chairman: I thought that was clear in your comments.

Mrs Cunningham: I hope so.

The Chairman: Thank you for coming before the committee and for answering the questions.

Ms Harris: Thank you.

MICHAEL WALKER

The Chairman: Our next presentation is from Michael Walker. Mr Walker, welcome to the committee.

Mr Walker: I am a lawyer, and I appear here today as a private citizen but also as a lawyer. A wise man, one of my mentors, once told me that a lawyer should never appear in public saying anything he is not being paid to

say, but I am here today saying this and I am not being paid to say it. Consequently, I will speak quickly.

I am a lawyer with the firm of Morris, Rose, Ledgett. I practice administrative law before administrative tribunals, primarily transportation law. The Ontario Highway Transport Board is the tribunal I am most familiar with. Surprisingly, there are some—

Mr Fleet: Excuse me, Mr Chairman. I would very much like to hear the comments. Perhaps you could get the press to move right out if they are going to interview people.

The Chairman: It usually takes a minute to change.

Mr Fleet: I am sorry to interrupt.

Mr Walker: There certainly are some areas that are surprisingly analogous between the regulation and deregulation of the transportation area and this regulation of independent health facilities act.

I have had occasion over the past 10 months or so to discuss this with a number of members of the medical community and some of those members, to be frank, are the type A, energetic, persuasive, entrepreneurial individuals Mrs Jensen spoke about earlier. My concerns are that we are not going to be encouraging those individuals to come forward with their expertise, their medical expertise and their management expertise, and with their money with the present legislation as it is drafted.

I have attached to my submissions an article that was written in December 1988 called Licensing Corner Store Health Care. That was published in our firm's newsletter last year. It is to some extent outdated. I congratulate the minister in that regard because a number of the submissions and comments that were made in that article, which was forwarded to the minister and members of the Ministry of Health, have been acted on. In particular, I deal with the proposed amendments dealing with inspectors and assessors and the qualification and appointment of those individuals. I congratulate the minister in that regard.

I will not address today other points in that article, the addendum to my submissions, because they have been and will be addressed by others before this committee.

There are really only about three points I would like to address this morning. One deals, first, with section 10 of the proposed legislation, which prohibits the transfer of a licence. I understand the concern about the trafficking in licences. Again, if I can relate to the regulation of the trucking industry, there was a similar provision recently introduced in the Motor Vehicle Transport Act that prohibited the transfer of licences held by trucking companies. It was a response to what was seen as a trafficking in licences, where the Ontario Highway Transport Board would license a trucking company and it would turn around and sell that licence to anybody, perhaps to someone who was not a fit carrier. The Ontario Highway Transport Board was understandably concerned about that assumption of its role by another individual.

That provision, the blatant prohibition against transfers, has caused some concern in the trucking industry now. I am concerned here that the transfer of the shares of the company could be seen to cancel the licence and



the licensee—the person, for example, who is buying the business, buying the clinic—would have to reapply for that licence. This could be a lengthy and expensive process. When there has been no change in the staff, the equipment or the need for the service, the proposed service or the service that has been provided, it is difficult to understand why there should be a blatant prohibition against the transfer of licences.

Sections 12 and 13 of the act as proposed, the amendments, deal with the transfer of voting shares of licences and the need to notify the director of any transfers. I would simply propose that an additional provision be considered dealing with the transfer of a licence in all circumstances where the licensee is obliged to immediately advise the director of a transfer. The director could undertake whatever investigation he deems necessary. If that investigation revealed that there was no change in the staff, no change in the equipment, no change in the procedures and no change in the need for the service authorized, then the transfer should be approved.

I have even greater concerns about section 16, which deals with the death of a licensee. There appears to be throughout the act an emphasis on a licensee as if it were a personal individual. One of my submissions is that we should start to think about it in terms of licensing a clinic, the business, not the individual per se.

Why have the director take control of the clinic, the facility, for a year pursuant to section 16 if the licensed individual dies, with no right to appeal or petition that decision according to subsection 16(4), when his or her son or daughter may be able to continue that clinic without change? That may not happen very often, but it may happen.

I have had occasion, dealing with the transportation industry, to deal with a situation where one of my clients, the president of a trucking company in northern Ontario, died. When I phoned the widow to express my condolences, I also had to say: "By the way, your husband's company, which he had for 30 years, which has been licensed for X years, providing this service, and which he has left to you and your son is no longer licensed. I have to open a new file and we have to apply for a licence because the death of your husband, the president of the licensee, affected the control of the company and nullified your present licence."

#### 1210

It was an unfortunate phone call to have to make. In the future I hope to be able to act for some of these licensees who are applying for licences to conduct business under the Independent Health Facilities Act and I hope I do not have to make that type of phone call again in the future.

There is another section, section 9, which authorizes the minister to direct the director in writing not to issue a licence with regard to any given proposal. An applicant cannot request a hearing in these circumstances and according to section 18 the minister may direct the director not to renew a licence as well. There is no provision in the legislation as originally drafted allowing for a petition to cabinet.

Again, if I can make reference to transportation legislation, there used to be a provision in section 22 of the Ontario Highway Transport Board Act that did allow for a petition to cabinet. Some of the members of the committee may have dealt with those types of petitions in the past.

It is my submission that we are dealing with issues of public policy here that are properly dealt with by members of the cabinet. Of course, you could say there is an appeal provision where you can go to Divisional Court on an error of law or apprehension of bias or whatever, but in practice those are expensive remedies and in fact no remedy at all for many individuals.

I believe the proposed amendments to the legislation addressing this issue in subsections 18(4), (4a) and (4b) are on the right track. That deals with a petition of a decision not to renew and allows for a petition to cabinet. I respectfully submit that those proposed amendments should be accepted by the committee and a similar right to petition should exist in section 9, but a petition to cabinet may not be of much help if the Minister of Health has already decided no licence should be issued and has said to the director: "Don't issue a licence to this person. I don't care what the district health office says, don't issue a licence to him and don't renew his licence if he has already had a licence."

Alternatively, perhaps in addition, the applicant should at least get, in my submission and in accordance with natural justice, a hearing before the board. In other words, section 8 should apply and we would therefore have to delete subsection 9(5), which says section 8 does not apply, and let the Health Facilities Appeal Board decide. Also, we would have to delete subsection 18(5), which takes away the rights to a hearing in section 19.

Another issue is section 11 of the proposed legislation, which indicates that every licence expires on the fifth anniversary of its issuance or renewal. The purpose of that provision is not readily apparent.

I am basically saying the application process may be a lengthy and expensive one. It is unclear why a licensee should be obliged to go through that process every five years, particularly if there have been no complaints concerning the service provided pursuant to the operating authority during that time.

Instead, it is respectfully submitted that the licence should be considered permanent unless revoked or suspended pursuant to section 17 of the proposed legislation.

In summary, it is submitted that the act is certainly on the right course. It addresses the reality that we cannot continue on our present course of action, the reality that all the people who have appeared before you whom I have listened to this morning, and I am sure on the previous days, are in agreement with, that the public wants accessible and expert health care in the community and due to technological advances we can provide that now at greater cost efficiency.

Unfortunately, from my discussions with representatives in the medical community now and over the past 10 months, I believe the legislation only represents a first step and the drafters of that legislation have to reassess it and look at the private sector as part of the solution and not part of the problem. I have not heard that this morning from any of the other representatives making submissions, but as long as we are spending one third of the tax dollar—the money has to come from somewhere.

I believe you can get that money from the private sector if you encourage it to come forward. You will not encourage them to come forward by giving them temporary licences, a confusing and possibly unfair application process, a licence that cannot be transferred, a licence that may be lost if

they die. In order to encourage the experienced and expert medical practitioners and entrepreneurs to come forward with their medical expertise, their management skills and their money, I suggest those amendments I have discussed.

The Chairman: Thank you for your presentation. You have pretty well used up the 15 minutes. We have three individuals who wish to ask questions. Perhaps we can go quite quickly.

Mr Carrothers: Just for my reference, Mr Chairman, how much time do we have before us?

The Chairman: We have used up the 15 minutes.

Mr Carrothers: Then I will be extremely brief.

Mr Walker: I would be happy to discuss with any members of the committee afterwards.

The Chairman: I think we can go very quickly.

Mr Carrothers: I want to deal with this issue of the need for the transferability of a licence. You have made the statement that it is sort of fundamental. What you are saying is it is a fundamental piece of getting people to come forward to run these facilities. It seems to me what we are dealing with here is the question of practice. Maybe we should focus on that and what this legislation is doing is dealing with where that professional practice—with the discussions this morning it might be other than medical, but let's just call it a professional practice—is carried out, and the business interest, if any, is that professional practice.

We are not creating a business opportunity. We want to create a business opportunity in running the facility; it is kind of an add-on or an adjunct, if you will, to that professional practice, and what we are doing is talking about creating some flexibility in where that takes place.

We certainly had some people come before the committee who are running clinics like this and indicating they are quite happy to come forward. I just put that to you. We seem to be getting two messages here. What I want to focus on is why that licence would have to be transferable. If the business interest, as I am indicating, is the professional practice, your own professional practice, your licence, is not transferable to another individual as an asset. You would have to sell your practice, if you sold it—which you could, I guess, when you are in a partnership—that would be transferred to someone else who is separately licensed.

Yet you do have some kind of business interest because that is what you are thinking of. You have a value. Basically, presumably, it is the clients list. It seems to me when we are dealing with professional practices usually the value of the practice is a letter from the old practitioner saying: "This new fellow is a pretty good guy. Why don't you continue to deal with him?" That is the business. That is the value. It has value. These practices are transferred frequently. In addition, presumably there are some physical facilities like desks, chairs, equipment which may have some value, leases and whatnot which may have some value that you can sell.



Mr Walker: And possibly laser machines or whatever that may have substantial value.

Mr Carrothers: Equipment might have some value and all of that is there without a licence being transferred. I guess what I am saying is that it seems to me that if we are sort of focusing on this as a professional practice, then there would indeed be value in operating one of these and someone could indeed transfer something of value without having a licence to transfer, not needing that. That is not a fundamental piece in encouraging people to come forward. That is the perspective I have. I wonder if you might comment on that.

Mr Walker: My feeling, my sense of it from discussing it with members of the medical community, is that if you are going to try to encourage the people with the management expertise to come forward and to go to the bank and borrow hundreds of thousands of dollars to set up a clinic, knowing that the licence may be temporary or whatever, they want to know that they have set up a business that can make some money and provide a cost-efficient, excellent service to members of the community—zap these cataract surgeries, in and out, whatever—and they want to know that if they get that to a certain point they can then sell that business.

Mr Carrothers: Okay. I guess maybe this is where it is a philosophical difference.

Mr Walker: But there is no change in the service. There is no change in the need for the service or the quality of the service. People come in, they set it up, they get it going and they move on.

Mr Carrothers: Would that not as likely happen with the five-year licences we are talking about, which equate really to—

The Chairman: Mr Carrothers, I think it is pretty clear to the committee what his perspective is and what yours is.

Mr Carrothers: They differ slightly.

Mr Philip: I want to ask you some questions on item 3. You talk about two courses of action where there is supposedly an injustice done, first, to either the licensee or the potential licensee, namely, the referral to the courts which you say is expensive; the other would be a procedure not available under this act which is petition to cabinet. Is this act not subject to a petition to the Ombudsman in cases where there would be an injustice done?

Mr Walker: I will have a look at it, sir. I do not know. It may well be.

Mr Philip: It seems to me that where there is an error in law, then the courts could handle it. If the tribunal, for example, went beyond the jurisdiction of its regulations or of the act, then there would be the two options—maybe the ministry officials can help us on this—either to go the more expensive route of going to the courts or the less expensive route of going to the Ombudsman and asking whether or not there has been an inappropriate decision made by the tribunal and whether it should be reviewed. I would ask you, if that is the case—I see nods from the ministry—why there would be a need to go to cabinet other than on the merits of the application itself. Is that the only case where it would be—



1220

Mr Walker: On the merits of the application itself, sir. The petition to cabinet would not be because he felt he had been treated unfairly. It would be because he felt there was an incorrect decision based on the evidence or based on the submissions in the proposals.

Mr Philip: Then my question to you is this: It bothers me why when governments set up tribunals, if they have done them effectively and if the regulations are clear, there should be a petition to the cabinet. If you are going to set up independent, quasi-judicial bodies to make decisions and then allow petitions to cabinet, do you not build in a certain amount of potential for misuse, patronage and so forth, and why would you want to do that?

Mr Walker: Absolutely, and I agree with you 100 per cent, except that in these provisions, as I read them, the applicant does not get a hearing before the board. The individual or business that wants to make an application does not get a hearing before the board, does not have, in accordance with natural justice, a day in court. If they have their day in court and they lose, they can go to court if they feel they were treated unfairly. In those situations perhaps there is no need for a petition to cabinet. Perhaps there might be even a possibility for abuse of the petition to cabinet and maybe that is why they did away with it when dealing with the Ontario Highway Transport Board.

Mr Philip: Now we are getting closer to where I think you are headed. Are you saying that because the minister has the right to arbitrarily, without any justification, not issue a licence or give a directive to not issue a licence, there is no check on that and therefore there should be a check.

Mr Walker: Either a petition to his or her colleagues in cabinet or at least let the person have the hearing before the minister arbitrarily decides, "Do not issue to this person," because there is as much potential for abuse there as there would be with a petition.

Mr Philip: Would you be willing to think about this? Maybe you could write back to us. Would you see any way of resolving your problem by perhaps narrowing the grounds on which a petition to cabinet might be acceptable and would you like to perhaps let us know about that once you have a chance to think about it?

Mr Walker: I would be pleased to.

The Chairman: I realize we are well over time, but I think it might be instructive to have Mr Sharpe give a point of clarification.

Mr Sharpe: I will not take that much time, I hope. I just point out that there is of course a distinction in the way the bill is cast in terms of the rights of appeal where on the merits of an application someone is turned down or a licence is revoked or suspended. There are the full rights to proceed, to appeal to the tribunal and from there to court. That would be on the merits. The director makes a decision.

I just want to make it clear that is separate from the exercise of ministerial discretion. I think the first day the hearings started I described the difference. When the minister decides to issue proposal calls, there is an important public interest dimension to that. The issues, as set out in the

bill, that the minister would consider are quite different from those the director considers on the merits of various applications.

When ultimately a decision might be made by a minister not to renew a licence, again the concerns are of a public interest nature. Are there sufficient funds to continue to support the operation? Is there a continuing need for the operation? Can the need be met in some other way? There, the proposed amendment is to permit, as you have indicated, a petition to cabinet. I do not know of any situation where the exercise of a public interest discretion by government is reviewable by a body like a tribunal or the courts. My understanding is that—

Mr Philip: Or the Ombudsman.

Mr Sharpe: Well, under the Ombudsman Act the Ombudsman ultimately has prevailing jurisdiction ultimately over government decision-making, agencies of government and so on. I would have to examine the legislation specifically to see if the various tribunals discussed here are caught. I would imagine they are.

Mr Philip: That is a matter that is before the courts at the moment.

Mr Sharpe: It is. It is under appeal, I believe. But I just wanted to make the distinction between the public interest exercise of discretion by government and the substantive decision by the director on the basis of the merits of applicants. In the latter case, there are full appeal rights, even for the initial applicant who is turned down.

The Chairman: The committee will have further opportunity to explore this with Mr Sharpe at a later time, if we need to. Thank you for coming before us and giving us your free advice.

Mr Walker: Thank you.

The Chairman: Our final presentation today is by the Scott Clinic and I would like to welcome Ms Maria Corsillo, the director of that clinic. Welcome to the committee.

#### SCOTT CLINIC

Ms Corsillo: Thank you very much, Mr Chairman, and ladies and gentlemen.

The Chairman: Sorry that we are well over time but we had a very interesting morning. As you followed along I am sure you saw that.

Ms Corsillo: Yes, it has been. I am speaking to you, of course, not as a politician or a political organizer. I am the administrator of an independent health facility and one which provides abortion services. I think that it must be fairly obvious by now that those of us who see and deal with patients and their problems on a daily basis feel quite differently about this proposed piece of legislation than do those whose main work is carried out in the political arena.

I have to say that what looks and sounds good on the front page of a newspaper or on television is a very different matter when it is applied to the individual patient. The Independent Health Facilities Act is for all patients in general and for abortion patients in particular a disaster waiting

to happen. I cannot stress that enough.

The actual substance of this legislation seems to have almost nothing whatsoever to do with the minister's stated objectives which, if I understand them correctly, are (1) to develop and enhance community-based health care and (2), to ensure quality health care and equity of access. The setting up of large, expensive bureaucracies of political appointees as the new power brokers in health care is bound to stifle every spark of creativity in this sphere.

Health care, like the housing industry, is going to be controlled and dominated by wheeler-dealer developers with money and political influence, at least, the political influence to get government contracts. The sweeping discretionary powers that have been accorded to the administrators of this act are a virtual guarantee that health care is going to become the next victim of political patronage and patient needs are going to be the very last consideration.

Consider, if you will, abortion services in the northern parts of our province. We know they are needed. The minister knows they are needed. Every hospital in this city that does patients from northern Ontario knows it and every health unit in the province knows we need those services. If the minister, who is accountable to the people of this province, has not increased access in northern Ontario, can we honestly expect a bureaucrat who is a political appointee, to suddenly wake up tomorrow and announce plans for a northern Ontario abortion clinic? We cannot.

I also want to give you an example of other health services that are going to be stifled by this particular legislation, something which may surprise you coming from an abortion clinic, none the less, we are a medical clinic and let me tell you about it. At our clinic, every day, every week, we see women who suffer from severe hyperemesis, a condition that totally debilitates them, forces them to be hospitalized, sent home and hospitalized again. They arrive in clinic in complete despair, abortion is a last resort, but they are totally unable to care for their families and their husbands do not know what to do with them any more. They practically have to be carried in.

Medical services in this province provide very little for those patients, aside from emergency entrance to the hospital, some rehydration, a few nice words, a pat on the back which says: "There, there, dear. The stronger the nausea, the stronger the pregnancy. Go home." They cannot go home because they cannot look after their families. Where do they end up? They end up with us because they have to terminate their pregnancies or life just will not be able to go on.

#### 1230

In Montreal, there are services provided by the Montreal diet dispensary which afford these women 24-hour care, nutritional services and the moral and mutual support they need in order to be able to prepare for future pregnancies and to carry through those pregnancies. I can tell you that is not available in Ontario. The reason I can tell you that is because I have spent long hours talking to health units, nutritionists, nurses and doctors. None of them have the time and none of them wants to be bothered other than to say, "Well, perhaps these women do not really want these pregnancies." That is simply not true. So, we are forced to send these women to Montreal to services outside of the province.



There are definitely people here in Ontario who would be willing and quite able to set up a clinic dealing specifically with this type of problem. They are not going to be able to under this legislation, and I can tell you the reason why. It is not cost-effective. The number of patients is very small. Are we going to say—and I can tell you that any minister looking at that is going to say it—the cost of providing this service for those patients just is not worth it? We are not going to do it. But we need it and those patients need it. They would be grateful to have that service and they would be able to have pregnancies which they really want but simply cannot seem to have, because of physical problems that they have.

This legislation is going to stifle all of that, because if I have had trouble convincing health units that such a problem exists, we are not going to be able to set that up. This legislation will also ensure that no one ever provides more or better abortion services other than what is currently available in this province. Even those services now in existence are not guaranteed by Bill 147. Note that even under section 7, the so-called grandfather clause enabling existing clinics to apply for a licence, the minister or director, without ever having entered an independent health facility, arbitrarily can decide to close it.

I do not expect them to visit us, although they would be most welcome. I would sort of like to take you on a brief tour of our clinic for a good reason. As I said, we are an independent health facility providing abortion services. We are a small clinic. We have been operating for the past three years in a renovated semi-detached building at 157 Gerrard Street East. We provide services for anywhere from 30 to 50 women per week. The large majority of our patients—this may be a total surprise to you, but according to our statistics, and we keep really accurate statistics—probably over 90 per cent, are not self-referred. They come to us from their family doctors. They come armed with test results, letters of referral, reports, etc.

They first see a trained counsellor, who explains the procedure and determines that the patient has made a clear decision. Patients who are ambivalent are counselled and referred to appropriate services in the community. Over the years we have developed excellent relations with area hospitals, referral centres, health units and social services because it has always been our feeling that an abortion clinic is not the place for a person to make her decision.

We can provide a patient with expert medical care once she has made her decision, but we should not, we feel, be the ones to help her make that decision. The patient then sees the physician who goes over her medical history, does an ultrasound and a complete physical. She is accompanied throughout by a counsellor and has her procedure performed by the physician who is assisted by an operating room nurse. It is done under a local anaesthetic. The patient is then observed in a recovery area. She goes over post-op instructions with the nurse. She receives post-op medication and an instruction sheet to take home and is ready to leave with her family or friends after about an hour. The whole process takes about two to two and a half hours.

Our physician sends the patient's doctor a complete report and the patient returns to her family doctor for her post-op checkup two weeks later. Between her visit to our clinic and her checkup, the patient has 24-hour-a-day, seven-days-a-week access to the physician who performed her abortion for questions, concerns, symptoms she does not understand and any problems that might develop.



Now why, you may ask, am I telling you all this? First, because I want you to know just how much the days of abortion as something shameful, tragic and terrifying are behind us. Abortion, when it is a good decision—a free decision—should lead to something positive in a woman's life. We always tell patients that if they have made the right decision, deep down they will feel good about what they are doing. If they feel this is a decision they will regret for the rest of their lives, then they should not be at the clinic. We respect our patients and they respect us. We respect their decisions and they respect ours.

Second, I want you to understand that abortion clinics in this city give first-rate care, care that does not need to be hidden inside so called reproductive health centres. This is not to say that we are opposed to reproductive health centres, it is simply to say that we as abortion clinics and as abortion care providers give absolutely first-rate care.

If you think this means we are very proud of our work, you are right. You would also be right in thinking that it makes us quite angry that after three years of hard work, some bureaucrat, basically accountable to no one (not even a court of law except on a point of law) can, under the flimsiest of pretexts (and that is how I describe sections 5 to 9 of this act) simply order us to close our clinic. It also makes us quite angry that other health practitioners will be unable to set up similar services for other patients.

Independent health facilities, in general, arose out of patients' dissatisfaction with the quantity and quality of services which hospitals and other health care institutions were able to provide due to budget cutbacks. Does the minister mean to achieve equity of access by using this bill to reduce all independent health facilities to the same sorry state as our hospitals? I am not referring here to quality of care, I am referring to the sorry financial state of all our hospitals. Does she intend by this to impose on us the same waiting lists, the same overworked, underpaid, harried and unhappy personnel, and the same inability to protect patient confidentiality?

Look at sections 30 and 30a. Can you honestly imagine a worse scenario than one in which a government functionary, an inspector or assessor or whatever you want to call him, is given immunity from prosecution for violating a patient's confidentiality, particularly when this concerns abortion services. What is to stop some unscrupulous inspector/assessor from setting up a lucrative blackmail sideline or simply selling names, addresses and phone numbers to those people whose sole function in life seems to be to harass and torment those who do not agree with them? Since the Attorney General (Mr Scott) of this province has virtually granted antichoice terrorists immunity from prosecution, is it necessary for the Minister of Health to give these people further incentive?

Last but not least, let me address the issue of the act's stated preference for nonprofit clinics. First, the term nonprofit as used by this act is totally unclear. Any corporation can designate itself nonprofit. How does the act intend to interpret this? Will doctors' and staff salaries, clinic costs, etc be set by the ministry? Otherwise how can nonprofit be applied in practice?

Second, abortion clinics in today's political climate are particularly vulnerable entities. Terrorism, vandalism, legal bills, high-tech security systems and crushing insurance costs are sad, expensive facts of life for us. Any clinic foolish enough to be unprepared financially to rebuild at a moment's notice would leave patients in serious distress and would encourage

similar actions.

If the minister thinks providing abortion services only in multipurpose clinics will provide protection for women, be aware that recent events in Ontario and elsewhere in Canada, notably Operation Rescue staged at Planned Parenthood in Kitchener and at Peter Lougheed Hospital in Alberta illustrate clearly that as the antichoice movement gets bolder and more arrogant, they will go anywhere abortion services are provided.

The honourable minister has stated again and again that her vision of equity and access means giving individuals and community: "More choice or empowerment...to have more say about their own health." This act is about giving individuals no control and the government all control over our health care decisions.

We recommend that the Independent Health Facilities Act should be completely revamped to ensure that individuals and grass-roots organizations can initiate, develop and run their own health care institutions and greater protection for individual rights, particularly with regard to confidentiality, must be built into the act.

The Chairman: We have several requests for questions beginning with Mr Reville.

Mr Reville: I want to thank you for your presentation. It is probably the first time some of the members here ever talked to anybody who worked in an abortion clinic.

Ms Corsillo: Yes, I realize that.

1240

Mr Reville: I want you to know that, having talked to a lot of people who have had abortion services in free-standing clinics and a number who have had abortion services in hospitals, often in hospitals it is still as shameful, terrifying and depressing and that is not what people say about the Scott Clinic or the Morgentaler Clinic or the Choice in Health Clinic.

Ms Corsillo: Yes, we are aware of those types of differences. I think I would like the committee to know that, as a clinic, we have sort of made a commitment to getting to know and contacting the hospital units in our area and in outlying areas as well. Our commitment is to provide abortion services for women and it is up to women to decide where the best place for them to have an abortion is. Some women have to be done in hospital. They have medical problems that require them to be done in that type of centre. Some women require general anaesthesia, so that is the best place.

I think our role is to help the patient to decide where she should be and to assist her in getting those—we are not here to say that abortions should only be performed in clinics and nowhere else. We like the type of co-operation that we get from hospital units and hospital staff.

There are a lot of changes that are being implemented in hospitals. Hospital units have come to visit the clinics. They have spent the day there. We have exchanged staff, just for observation and to learn. There are lots of things that we have learned also from our hospital colleagues, so it is not sort of a case of one or the other.

We are really interested in providing the very best abortion care in Ontario and we are hoping that all of us, abortion care providers both in hospitals and in clinics, will be able to come together on a regular basis so that we can give the very best care.

Mr Reville: The thing that irritates me most about this bill is that a government that has declined to ensure access can wipe out the work of those people who stepped in to provide it just with a stroke of the pen.

Ms Corsillo: Yes.

Mr Reville: There is no guarantee that this legislation is enabling in any way. The minister has so much power that even if a district health council were to say, "We've got an access problem in our district," there is nothing that says the minister has to fund a specific proposal or any proposal at all.

Ms Corsillo: We have talked to people on district health councils across the province over the past three years and all of them agree there are access problems.

It has been three years. There have been many proposals on the books. Peterborough is one that comes to mind immediately. Well, where is it? It is still not open, and basically women from Peterborough are travelling every day to Toronto.

Mr Reville: There is a little politics going on there, I think.

Ms Corsillo: Yes, well, everywhere. If under the present situation we have not resolved some of these access problems, and the district health councils always wanted to talk to us, but it always had to be hush-hush: "Don't tell anyone you've talked to us. Don't let anyone know you were talking to us—"

Mr Reville: It is a hell of a way to plan health care, is it not?

Ms Corsillo: Yes, exactly. How is that going to change? It is the same people.

Mr Jackson: My questions have to do with this area of confidentiality. I am trying to get a better handle on its application to this bill generally and its application specifically in the case of abortion.

I guess it is now becoming more apparent to me that when you talk about guerrilla actions or terrorism or whatever you want to call it, whether or not I agree with you, that is not the issue. The issue here is that one of those actions might be also classified as an act of conscience; if, for example, a civil servant felt according to his or her conscience that he or she should release all these names of a person in a clinic. There are examples of this.

Mrs E. J. Smith: Then they could go to jail.

Mr Jackson: Yes, we have people who gave—

Mrs E. J. Smith: That is not conscience, to break the law.

Mr Jackson: You understand the concept I am trying to convey to you.

Ms Corsillo: Yes, I understand.

Mr Jackson: Is that an additional kind of concern you have? Is that what you were talking about?

Ms Corsillo: I am talking about that. I am talking about whether it is inadvertent, whether it is intentional—

Mr Jackson: Well, all of those. But you are saying abortion particularly lends itself to a different threshold of—

Ms Corsillo: Let me give you a very simple problem: the Ontario health insurance plan. Billing OHIP for an abortion is done under a confidential family planning code. That same kind of principle can apply: a simple telephone call to a patient's home, stating, "Did you visit such and such a place and did you have an abortion procedure?" as a verification of service, etc. Often no care is taken as to who the person is on the other end of the line. It is simply, "Hello, is this—

Mr Jackson: You are leading into my second question, because I understand the choice agenda, even in a marital agreement, pledge, oath or whatever, is that there is no binding obligation, in your view, to share with the spouse the information that you have had an abortion—

Ms Corsillo: That is not my view; that is the law.

Mr Jackson: Thank you. Well, you have clarified it. That is a point of law that—

The Chairman: I think Dr MacMillan has a point of clarification.

Mr Jackson: I am just trying to understand this.

Dr MacMillan: I think it is not fair to leave the committee with the mistaken impression that phone calls are made to verify that somebody has visited an abortion clinic. The presenter knows that we have in Ontario an insurance scheme. We pay claims. I and my 100 staff have every name of every person who has attended your clinic and have had ever since the day you opened.

Ms Corsillo: Yes.

Dr MacMillan: To add an inspector—I just wonder whether you have had breaches—

Ms Corsillo: We have had one and we were not able to ascertain where the breach occurred. The patient refused to do anything about it; otherwise you would have heard about it and we would have let you know. As it turned out, it did not result in anything terrible happening; the problem for the patient was that it could have. We have have had only one. There have been 5,000 cases, so that is not—

Dr MacMillan: I would just point out that there are millions of claims at OHIP per year.

Ms Corsillo: There are many patients who will not use OHIP, because they are afraid that that will happen.

The Chairman: Dr MacMillan was simply clarifying the point, when you



made reference to a call being made, that that is not the standard procedure. That may have been an unfortunate exception to what is standard procedure.

Mr Jackson: I was just building my understanding by asking some questions. My next question: The Toronto Psychoanalytic Society came before us yesterday with concerns about confidentiality. They suggested that all documents that may be removed and/or examined should be prescreened and the name or any identifiers blocked before a document is released in that form to the ministry officials who are undertaking a review to ensure that the procedure was done and that there was no additional facility fee charged. We understand the reasons why they are in there.

The society went on to recommend a few other things, but I just wanted to get some feedback from someone in an abortion clinic with respect to the suggestion, because they were saying it would apply to abortion clinics but there was nobody there in the panel. They were dealing with psychological services and the need for confidentiality.

Could you react to that suggestion or what they had recommended as an amendment to us?

Ms Corsillo: Looking at it now after hearing it from you, yes, that is one way of guaranteeing greater confidentiality. Our concern is not with a physician from the College of Physicians and Surgeons of Ontario investigating care or anything like that. We have no difficulty with that whatsoever.

Our concern is with patients' names that are come across by inspectors or assessors for other reasons, whether they be financial or other, in that use could be made of those names in other circumstances; so, yes, some way to protect patient confidentiality under those circumstances would be very welcome.

1250

Mr Jackson: Mr Chairman, how are we fixed for time? I have two other questions.

The Chairman: We are well over time. We have two other questioners. If the committee is prepared to—

Mr Jackson: I will yield at this point.

The Chairman: If it is the committee's sense to continue, we will come back to you.

Mrs E. J. Smith: I appreciate the opportunity. I must say I appreciated much of your presentation. I was interested in your point of view that abortion clinics, as pure abortion clinics, have a role. I found, particularly in a city of this size, that a very interesting point of view.

However, having come recently from the Solicitor General's office, which touches closely on the Attorney General's, I find myself taking very strong exception to your statement. I feel it necessary to ask you about your statement that the Attorney General of the province has virtually granted antichoice terrorists immunity. I found that extremely difficult in light of the actual fact of what is happening out there. I am sure you would agree that the rights of both pro-choice and pro-life groups to express their points of view must be preserved under law.

Ms Corsillo: Yes.

Mrs E. J. Smith: I think you would be aware of the case of the police officer who would not preserve the rights of the pro-choice people to behave in an orderly and legal way outside the clinic in protest and the fact that his career—I do not know if it under appeal, so I will be careful—was certainly interrupted and possibly changed by virtue of his not adhering to strict behaviour for law enforcement and the rights of both groups to be heard. In light of that, I wonder if you would reconsider such an extreme statement, because I find it does not measure up to the facts of law enforcement in this province.

Ms Corsillo: I think that if you look at the reality of what is happening—Outside our clinic, every time there is such a thing as an Operation Rescue staged, the fact of the matter is that not one, not a single one of those people who have been arrested and charged—Not for protesting. We have absolutely no problems with people walking up and down, carrying signs, handing out all the literature they want to hand out. That is not what I am referring to.

What I am referring to is an organization that chooses, on some given day at six or seven o'clock in the morning to send out an advance group—and I should have brought the picture so that you can have a look at them—These are huge men, 12 or 13 of them, who simply throw themselves right up to the door of the clinic so that no one can pass, no one can get through. The last Operation Rescue, we had patients locked in the clinic. We had a woman who was there with her mother who was a diabetic and had to have her insulin shot by a certain time. We could not get her out of the clinic. These people have not been charged.

Mrs E. J. Smith: I am sure, to not get into long examples of individual cases—

Ms Corsillo: These people have been taken away to the police station and released. Why have they not appeared in court? That is immunity from prosecution. You can go out and do this repeatedly and nothing will ever happen to you. You never have to answer for it. That is not legal protesting.

Mrs E. J. Smith: I believe that by and large the protesting has been kept very much within law and order. Throughout our society, throwing people in jail is not very often done on a broad basis. I would take you to Temagami and protesters and so on. By and large, protesters are mostly not held in jail for long.

Ms Corsillo: You would not feel the same way were you the recipient. Four or five times in six months may not seem excessive to you, but if you are trying to provide care for patients on a daily basis and have to worry that every morning you might get up and get a call at seven o'clock in the morning: "Guess what folks? We have a group of thugs on our stairs who say we cannot go in or out." That is not what is supposed to happen in a democratic society.

Mrs E. J. Smith: I agree.

Ms Corsillo: Those people who want to violate those rules—I did not say they had to go to jail; I said that they should appear in court and they should have to answer for their actions. That has not happened.

Mr Fleet: Have you not sworn out a private complaint at any time?

Ms Corsillo: That would be really interesting, if you tried to do that. I have tried to obtain from the police the names of those individuals arrested so that we could prosecute them ourselves, and what I was told was: "Have your lawyer write us a letter. Tell us the laws that these people are deemed to have breached, and then we will consider whether we will release those names." That has been the official reaction.

Mr Fleet: It is my understanding there are other ways you can pursue it, but I will not go into it.

The Chairman: We are well over time.

Mrs Cunningham: Some days it is hard to take the high road, is it not? I very much appreciated your presentation. I do not know how better how I can be sincere about it. You appear to me as a person who is providing a very professional, needed medical service and have done it for some time, at least made this kind of a contribution. You know how these kinds of independent health facilities can work, if we could just take the politics out of the whole thing. I am going to look towards a vision, because I really think that 10 years down the road, we will not be having these arguments—maybe two years, if we are lucky, maybe six months; I do not know—from the political point of view, around the question of providing good medical care.

What I am interested in: First, we have asked a lot of questions and a lot of concerns have been expressed around the confidentiality. There was a very interesting brief, as my colleague mentioned yesterday, where there was a specific amendment that may be helpful. We would like to get back to you on that to see if it would work in a practical way. My work has been audits of family benefits and not health, and certainly education, where there is a chance that we could be making a mistake. I am sure the staff is more than interested in not having mistakes. So we will get back and try to be helpful in our criticism.

The other group that came before us today was the Registered Nurses' Association of Ontario. They had one person who has been tremendously involved in audits right across Ontario, where confidentiality has been an issue for her. I just wanted you to know we are going to do some work and we may get back to you to be helpful.

The other point I would like to raise with you is, in all practicality, if we looked at your operation as a model for an independent health facility down the road, the one question that everyone has is the one you raised too, and that is this nonprofit part. You were quite right; no one knows what that means. I have been in a position of licensing nonprofit groups for the government; they vary from people doing the same job earning salaries from \$20,000 right up to \$100,000. I can assure you that everybody in this room is wondering what nonprofit really means, and for good reason, because it has not been defined. I think the staff said they were working on that, if I am not mistaken, Mr Chairman?

The Chairman: Yes.

Mrs Cunningham: So that one will work and feel quite free to get in touch with any one of us to see if we have done our homework, because that is what we are supposed to do.

The part I would like to ask you a question about—You may prefer not to respond, because it has to do with finances. It is one that is confusing, I



think, to many of us. When we are billing OHIP for the fee, that is a certain part of the operational budget of the clinic; you are pulling in some money to help support the services that are being provided.

Ms Corsillo: The only OHIP billings that are made to OHIP by our clinic are: one, the physician bills OHIP for the abortion procedure itself. I cannot remember what the fee is: \$90-odd—

Mr Jackson: Just over \$100. We are told \$102.

Ms Corsillo: And when the physician performs an ultrasound, he bills OHIP for the ultrasound.

Mrs Cunningham: I am sure a lot of people who want to get into the business of supporting these independent health clinics could go to you for some budgeting advice. The point I am trying to make here is that there are a lot of overhead fees that are costs, including capital. They vary from procedure to procedure or whatever the service may be. I am sure you must have another fee you have to charge people for coming.

Ms Corsillo: Of course, and the reason for that is quite simple. If you recall, when we started out three years ago and considered the position that abortion as a service was in, in this province, it was impossible, although we tried, to rent facilities. That meant we had to buy a building and it meant we had to have all of the startup setup costs. We sought advice from other people who had done the same thing in other cities, etc, and they all told us the same thing: If you want to function and run a quality clinic, which is that you want to provide the very best equipment, to be able to renew that equipment as need be, to be able to provide the kind of environment that you think should be provided, this amount would be what you have to charge. That amount was about, I think at that time, somewhere around \$300. That is plus the OHIP.

1300

If a patient has no OHIP and comes to the clinic, she is charged \$340 if she is under 12 weeks. That is without OHIP at all. If the patient has OHIP and is under 12 weeks, she is charged \$200 for clinic costs. We always gave receipts, but since the Supreme Court decision, we have been giving complete receipts to patients detailing what the \$200 was for. Some patients have submitted them on their income tax, some patients have submitted them to health plans at work. To date, I think there are only three I have heard of who have had it reimbursed at work through a health plan.

Mrs Cunningham: In the \$200—

The Chairman: Mrs Cunningham, we are well over our time limit. I would like you to draw things very quickly to a close.

Mrs Cunningham: I understand. I will certainly be in touch with the—

The Chairman: As you know, we are starting at two o'clock.

Mrs Cunningham: I know. I want to close by saying that I found the group, as did others, I am sure, particularly open and sincere about its service. I think it would be a good model for setting up independent health facilities across the province. The one point I particularly appreciated around procedures was the point you made—I am not sure whether it was in



response to Mr Philip's or Mr Reville's question—that we have to do this in co-operation with hospitals, because so many people need that other part.

Ms Corsillo: Yes, you are right.

Mrs Cunningham: I really appreciated that.

Mr Dietsch: I want to ask one question relative to confidentiality, which I found rather interesting in the comments that were made. How many staff members do you have working for you?

Ms Corsillo: It depends on whether we are doing clinic days, but we have four nurses, two counsellors, myself, Dr Scott and a cleaning staff.

Mr Dietsch: What security methods do you use, in that someone who works for you might turn out to be one of these conscience persons in the long term and breach confidentiality of individuals?

Ms Corsillo: Nurses have their own rules of professional conduct. They can be held liable for breaches of confidentiality. In addition to that, we as a clinic would hold ourselves responsible were anyone to breach confidentiality in that way.

Mr Dietsch: The point I am making is that it does not necessarily mean the confidentiality will not be broken. I was just intrigued by your comment—

Ms Corsillo: But we can be prosecuted.

Mr Dietsch: Absolutely, and so can the individuals who break confidentiality doing government work.

Ms Corsillo: That is not our understanding of it, that they can be.

Mr Dietsch: Yes, they can.

The Chairman: Thank you for coming before us and giving your point of view on the bill. We are adjourned until 2 pm.

The committee recessed at 1305.

CA20N  
XC12  
-578

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

INDEPENDENT HEALTH FACILITIES ACT, 1989

WEDNESDAY 16 AUGUST 1989

Afternoon Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Dietsch, Michael M. (St. Catharines-Brock L) for Mr Daigeler

Fleet, David (High Park-Swansea L) for Mrs O'Neill

Hosek, Chaviva (Oakwood L) for Mr Beer

Philip, Ed (Etobicoke-Rexdale NDP) for Mr R. F. Johnston

Reville, David (Riverdale NDP) for Mr Allen

Smith, E. Joan (London South L) for Ms Poole

Clerk: Decker, Todd

Staff:

Drummond, Alison, Research Officer, Legislative Research Service

Witnesses:

From the Medical Reform Group of Ontario:

Divinsky, Dr Mimi, Steering Committee

Berger, Dr Philip, Steering Committee

Frankford, Dr Robert, Steering Committee

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriele L)

MacMillan, Dr Robert, Executive Director, Health Insurance Division

Sharpe, Gilbert, Director, Legal Services Branch

From the Association of Ontario Midwives:

Hutton, Eileen

Schear, Leslie

From the Cernelian Health Services Cooperative Inc:

Eggleton, Sandi, Director

Burgess, Bonnie, Director

Shaw, Margaret, Director

From the Ontario Medical Association, District 11:

Berger, Dr Joseph, Chairman; Assistant Professor of Psychiatry, University of Toronto

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 16 August 1989

The committee resumed at 1405 in committee room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: We will call the meeting to order. This is the standing committee on social development, convened to consider Bill 147, An Act respecting Independent Health Facilities. I would like to welcome back members of the committee and visitors and various delegations for this afternoon.

The first group to appear before us this afternoon is the Medical Reform Group of Ontario. Representing that organization is Dr Robert Frankford, a member of the steering committee. Would you take a seat over here.

Welcome to the committee. You have about half an hour for your presentation. Committee members usually appreciate it if you leave some of that time for questions. I would like you to start by introducing the other members of your delegation.

MEDICAL REFORM GROUP OF ONTARIO

Dr Divinsky: I am Dr Mimi Divinsky. On my left is Dr Philip Berger and Dr Bob Frankford. We are all family doctors in Toronto and we represent the Medical Reform Group of Ontario, which is an organization of physicians and medical students, largely Ontario-based, mostly in Toronto and Hamilton.

Our three main principles are that health care is a right, that everyone in the province and in the country should have access to high-quality health care; we worked hard against extra-billing, and we also believe there should not be premium payments for health insurance coverage.

We try to look at social and political causes of health and stay away from the germ/disease model theory.

We also believe that other health care professionals can make a significant contribution to the health of the community.

With these three principles in mind, Dr Berger is going to start our presentation with regard to this legislation.

Dr P. Berger: I would first like to thank the committee for the opportunity to express our opinions on Bill 147. We also appreciate the Ministry of Health's widespread consultation on this bill. Earlier this year, the Medical Reform Group discussed the bill as approved at second reading by the House with Ministry of Health officials, and we are grateful for that as well. We also are grateful to the ministry for releasing a copy of Bill 147 showing amendments proposed by the minister.



We have studied in detail the original bill and the bill with the proposed amendments. Our comments today are directed largely towards the latter.

In analysing Bill 147, it must be noted that the only feature distinguishing health facilities from independent health facilities is that independent health facilities charge fees that support, assist and are a necessary adjunct to an insured service but are not part of an insured service. Health facilities do not charge such fees; that is, any health facility such as a private doctor's office that charges a fee on top of the Ontario health insurance plan billing is classified as an independent health facility.

Under section 1, the fee is called a facility fee. Sections 1 and 2 define "health facility" and "independent health facility" based only on whether a facility fee is charged.

Under Bill 147, it is our view that nearly every private physician's office or clinic practice in Ontario could be defined as an independent health facility and subject to the full force of the act. Section 33 catalogues cabinet's right to make regulations which determine what services and costs constitute a facility fee, and along with section 34, cabinet will be accorded the power to determine what constitutes an insured service.

As it stands now, almost every physician charges fees for costs that under this act could be defined as a facility fee, costs which are clearly not part of an insured service. I am not just talking about doctors who charge administrative fees, which are addressed under paragraph 33(1)27.

Let me give you an example of the law-abiding general practitioner who does not extra-bill under the ruse of administrative fees but does charge patients genuine costs incurred in practice, costs not currently covered by the insured service and costs necessary to provide the insured service.

Some general practitioners buy intra-uterine devices in bulk at cheaper prices and charge patients the cost of the IUD. The IUD is a necessary adjunct of the insured service of inserting the IUD but is not part of the insured service. These doctors buy the IUD to save patients money and the inconvenience of purchasing the IUD from drugstores, which often do not have the IUD in stock. Under Bill 147, these GPs would be charging a facility fee, thus triggering the application of the act.

#### 1410

Similarly, doctors who charge patients the cost of long-distance phone calls, which I have done myself, those calls being required for patient care, telegrams—which I have done myself, to contact a patient who was in Chicago and I needed to communicate with him about an urgent laboratory result—or doctors who charge patients the cost of medications purchased by the doctor would all be subject to the act provisions. These doctors will all be defined as independent health facilities.

Under sections 3, 24a to 24d and 26, specifically subsection 26(4), most Ontario doctors will be subject to search and seizure of their medical records without warrant. The minister's proposed amendments do ensure the College of Physicians and Surgeons of Ontario inspectors and assessors would seize the records, not ministry employees as in the original draft, but this is small comfort to doctors who suddenly find themselves classified as independent health facilities.

The act would, of course, apply to physicians who charge administrative fees or to those psychiatrists, for example, who still extra-bill. This is not a bad thing and we have no objection to enforcing a ban on extra-billing through ensuring compliance with section 3 of the act. It should be noted that where a doctor resists an inspection by a college inspector under section 26, and again particularly a psychiatrist, then the inspector can seek a warrant under section 27 without providing notice to the doctor that a warrant is being sought. The doctor would have no opportunity to argue or contest this warrant in court.

We have no objection in principle to the provisions of the act, sections 24 to 27, that allow for review of the quality of medical care provided in doctors' offices, but it is strange that what triggers these evaluations is the charging of a facility fee. As it stands now under the act, a doctor who wants to escape the act's quality assurance provisions could forfeit recouping legitimate costs from patients and never be subject to review unless caught by the college peer review program or complaint system. If the government wants to monitor the quality and standards of medical practice in Ontario, then why does not government just come right out and do it?

The Medical Reform Group of Ontario is concerned about the extent of power accorded the minister in issuing and renewing licences of independent health facilities. Under section 9, a minister can decide not to issue a licence, and the appeal mechanism set out in section 8 does not apply.

Similarly, under section 18, the minister can decide not to renew a licence and the appeal mechanism set out in section 19 does not apply. The minister's decision is final and not subject to appeal. Only the director's decision under section 6 for issuing a licence and under section 17 for renewing a licence can be appealed. But the appeal mechanism offers little relief if the minister overrides a director by applying sections 9 and 18.

As it is, under section 21, any decision or order of the Health Facilities Appeal Board can be appealed to the Divisional Court on a matter of law only. A decision of the Divisional Court is final. This is a lot of power vested in government with scant chance for appeal by an independent health facility.

We see sections 6, 8, 9, 17, 18, 19 and 21 as particularly relevant to abortion clinics. A minister, director or board with an antichoice position could easily shut down abortion clinics right across the province. There would be no appeal of the minister's decision and an appeal only to Divisional Court for the director's and board's decisions. We have already witnessed the recent response of higher judicial bodies on the abortion issue in Ontario and Quebec. Furthermore, under section 20, the board may specify any person as party to the appeal for an independent health facility, persons beyond the independent health facility requiring the appeal. This means that an appeal by an abortion clinic can include antichoice groups. The appeal process could well become another battleground for antichoice groups to prevent women from exercising their right to choose abortion.

Our greatest worry, though, about this act is a real possibility for introducing government-sanctioned user fees under the name of facility fees. The act's wording and intention are confusing in this regard. Subsection 3(3) of the first draft, the unamended draft, says that OHIP-insured persons cannot be charged a facility fee in an independent health facility except as provided in the regulations. The draft with the minister's proposed amendments deletes the caveat of the regulations and seems to state unequivocally that insured

persons attending a licensed independent health facility cannot be charged a facility fee. However, under paragraph 33(1)1 the cabinet can exempt independent health facilities from application of the provisions of the act, thus permitting facility fees. Paragraph 33(1)25 allows cabinet to make regulations fixing the amount of the facility fee.

Finally, section 23 says that the minister may pay all or part of the cost of an independent health facility. This all adds up to a facility fee, making up the portion of costs not covered by the minister's funding.

In our view, facility fees should not be used as a source of funding for independent health facilities and should not be charged to any insured person attending an independent health facility. Facility fees used in such a manner will impede access to those who cannot afford to pay, a return to the days of widespread extra-billing.

The services of independent health facilities should be equally available to all, regardless of ability to pay, and those services should be completely funded by the ministry.

Subsection 3(3) of the proposed amendments should not be subject to cabinet regulation.

This act provides other extraordinary powers to the government. Not that all are bad, but these powers must be clear to this committee and to the public, for the entire way medicine is practised in Ontario could change profoundly.

First, under paragraph 33(1)6, the cabinet can make regulations classifying health facilities and independent health facilities. All nonhospital medical practices in Ontario will be subject to cabinet classification.

Second, under section 23, the minister will be able to determine "whatever method of payment" is accorded to those practices or clinics classified as independent health facilities. This is the first time, to our knowledge, the government can first classify medical practices and then determine the method of payment to the doctors operating those practices if they are independent health facilities. Fee-for-service medicine might indeed be gasping its last breaths of air.

There are other sections of the act that cause us some concern, although less so than the areas we have raised. Specifically, sections 5, 10, 16, 17 and many parts of section 33 are imprecise and require clarification by the ministry. All in all, the act provides sweeping powers to the Ministry of Health and cabinet unprecedented in Ontario's history.

We do support the intention of eliminating unwarranted financial charges to patients that would impede access, such as administrative fees. We also support the principle of monitoring the quality and standards of practice in Ontario. The committee and public should understand exactly the means the government proposes to achieve these objectives.

Mr Carrothers: I want to go back to your comments on facility fees. You are interpreting the words in the legislation broader than I would have done and the net seems to be cast much broader than I was taking it to read.

You see section 2, I guess.



Dr P. Berger: Yes.

Mr Carrothers: Do you not feel that section is covering off the difficulties you are talking about, in terms of some of these incidental fees that sometimes get charged by a doctor's office, by basically exempting an ordinary doctor's office?

Dr P. Berger: It only exempts the doctor's office if no moneys are charged. If a penny is charged, then automatically the doctor's office, which is a health facility, becomes classified as an independent health facility, unless it is exempted under cabinet regulations, section 33.

Hon Mrs Caplan: It might help with some clarification from the ministry on that point. I think it is an important one.

Dr MacMillan: Dr Berger, the explanation and the reason you have fallen into that trap is that you have looked at that legislation in isolation. You must also look at the Health Insurance Act and its regulations. As you know, the schedule of benefits is a regulation. If you look in the front pages of the schedule of benefits, you will see a list of uninsured services, the very ones that you have mentioned.

There are going to be three categories of services. There will be insured services; that will be very clearly delineated in the new schedule of benefits, which will be written to explain the constituent elements of the fees. There will also be uninsured services, which is a list that has been finally agreed to in essence between the people in my area and the Ontario Medical Association. There will now be facility fees under these regulations and this proposed legislation; instead of all the doctors in Ontario, there are roughly 20 physicians who are charging who fit this category of facility fees.

Dr Berger: I could put it back to you. I think this is quite important. What we do not know, of course, is what is going to fall under each of these different categories. According to the way this act is set out, without even reading the front page of the act you refer to, if any money is charged in respect of an insured service—and I interpret that to mean naturally flowing out of an insured service and intimately bound up in that insured service, but not part of it, and that is how I read this act—then that would be classified as a facility fee unless cabinet does what you say it is going to do and have these different categories.

I put it to you, what about a long-distance phone call on behalf of a patient? What category is that going to fall into if the doctor wants to recoup a legitimate cost on behalf of that patient? As it stands now, this will be called a facility fee. It is certainly necessary and flows out of an insured service.

1420

Dr Divinsky: Can you give us an example of what has been designated as a facility fee?

Dr MacMillan: No, but the phone call is a good example, because you can read in your schedule of benefits right now that phone calls are not an insured service.

Dr P. Berger: Right, but it is in respect of an insured service.



That is the point. I think it is quite clear in here that a long-distance phone call to contact someone who has active syphilis certainly supports and assists and is a necessary adjunct to the insured service which brought the person in in the first instance. What follows is the long-distance phone call. It is not part of the insured service, but it certainly supports and assists the insured service.

Hon Mrs Caplan: Just to restate, it is the intention to clarify by regulation very specifically that which would not be considered an insured service. Telephone calls and the sorts of things you have just identified, Dr. MacMillan said very clearly, would not constitute a facility fee. Therefore, what will happen through the intentions of the clarification of the Ontario Health Insurance Act will be the kind of clarity that has not been present, which I think will be of assistance to everyone, both those who are working out of Kingston as well as physicians. There have been a lot of grey areas. What they are doing now and what this act will allow is that kind of clarity. They will not constitute a facility fee.

Dr P. Berger: That is somewhat reassuring. The problem we have is that information is unavailable now, publicly at least.

The Chairman: I think it has been helpful to have this exchange and hopefully get it clarified.

Mr Carrothers: If we assume that we have this clarified for the point of discussion, then I want to move on to your comments on search and seizure. I think I heard you saying, and I want you to say it again, because I thought I heard your concern might have been predicated on the fact that because the facility fee was so broadly based, that basically meant that almost everything going on would be subject to search to see if there was a violation of this act.

If we assume that the ministry is right and we get it all clarified that it is a much narrower concept focusing in on capital costs and operating costs, which is what I understood it was supposed to be, do you still have concerns on that search and seizure? Maybe you could explain it to me again, because I may have missed the point.

Dr P. Berger: I think I can explain it to you. If there is a feeling or an "opinion," to quote the act, by the director that there has been noncompliance with section 3, then under section 26 the college registrar can appoint an inspector who can enter a health facility without a warrant. It is the view of our group that that is overly intrusive. I think the inspector should probably be required to argue that in court when a warrant is being sought. It is better than the original draft, for certain, because the original draft allowed direct employees of the ministry to do that. I feel safer with the college doing it. It is at a much greater distance from the government.

I think some of the psychiatrists who have been here would be particularly troubled by college inspectors being able to come in without a warrant. They would not have the opportunity, for example, to argue their case in front of a judicial authority.

Mr Carrothers: I thought theirs was more on confidentiality.

Dr P. Berger: Yes.

Mr Carrothers: I am just wondering, is that not what happens now regarding OHIP and the possibility of difficulties with OHIP?

Dr P. Berger: It happens under several circumstances. In the one under the peer review program, the college has a right to come in and look at medical records. I do not think they have a right to seize them, but they can look at them. If there is any complaint registered by a patient, they have the right to go in. If the college takes notice of public events like the Dubin inquiry, for example, it can decide to investigate a physician.

Mr Carrothers: That is all done without a warrant, is it not?

Dr P. Berger: Yes.

Hon Mrs Caplan: There is one other case, just to interject. It is not correct that where OHIP has a concern about inappropriate billing to OHIP it can today request the college to go in to investigate the billing practices. What is proposed here is that where there is a concern about inappropriate billing to an individual, the same route that is presently available when there is concern about inappropriate billing on behalf of that individual through OHIP, the same procedure would apply as presently exists today, and that is that the college sends in an assessor and he comes in without warrants. Is that not correct?

Dr P. Berger: The concern I have, which might be less of a concern now, is that many doctors in Ontario are going to be caught in this net of the definition of "facility fee," and this would apply to that. What you are saying to me—and I am reassured by your comments—is that "facility fee" will be defined in much narrower terms and far fewer doctors will be subject to this.

Let's say we go along this route of thinking. An inspector tries to get in without a warrant, but the doctor resists, the psychoanalyst resists. I think in that case—and I refer to section 27 specifically—at least some notice should be given to that doctor that a warrant is being sought.

Hon Mrs Caplan: The question is what happens today.

Mr Carrothers: You do not get notice that a warrant has been issued against you.

Hon Mrs Caplan: What happens today is that there is a concern that that same physician is inappropriately billing OHIP.

Dr P. Berger: I am not sure of the details of the procedure. I presume they get notified.

Hon Mrs Caplan: I think that is an important point.

Dr MacMillan: I think the chairman explained that you will find, when you hear the college's presentation, that they are strongly opposed to warrants. They are not police officers, they are professional reviewers. They have never wanted warrants. Whenever the Ontario health insurance plan notifies them of possible breaches in billing patterns, they always pick up the phone, do not surprise the doctor, arrange a convenient time and go to visit. To land on the doorstep, they say, with a warrant from a judge is not the route they wish to choose. That is one of the reasons the legislation was drafted in this way, to comply with what the college says. I think the college

will go on record as saying they will not be involved with this peer assessment if a warrant is involved.

Dr P. Berger: I concur with that analysis, but I am talking about a situation where a physician resists, under this legislation, inspection by a college inspector. The next step under section 27 is that a college inspector can then seek a warrant. The only discomfort I am registering is that if that doctor was to argue against the warrant being sought, for example argue that there is no justification, no reasonable ground, which is the phrase under section 24, to go into that office, the doctor will not have an opportunity to argue against that warrant. I am even reassured the college does not want to go after warrants, because maybe they will just stop and not ever use section 27.

The Chairman: Do you have any further questions?

Mr Carrothers: I guess we may have exhausted it. It is just that my experience with warrants is that they are issued and you do not know they are coming. They just have to get the judge to swear it out. So I am not sure you get that chance. If you object, I think you can request the files be sealed while you get an argument, but that is after the warrant has been issued.

I think the discussion on the psychoanalysts, if I remember, was more relating to confidentiality of the names of the patients, which is a slightly different situation than what you are putting forward. They wanted some ability to keep the names of the patients confidential.

Dr P. Berger: One way, I suppose, would be to have a limited warrant or a warrant specifying exactly what information.

Mr Carrothers: Or some procedure where you could delete the names in the files.

Dr P. Berger: Yes.

Mr Reville: I should start by wishing you a happy anniversary.

Dr P. Berger: An in-joke.

Mr Reville: It is too bad it is so in, is it not? One of the problems with this place is that sort of thing is an in-joke.

Mrs E. J. Smith: You have to know the joke to know what the problem would be.

Mr Philip: I do not get the joke.

Dr P. Berger: I was afraid of that.

Mr Reville: You point out in the brief you submitted, although you did not say this, that if the government was interested in improving access to abortion services and creating alternatives for birthing, it would not need this legislation. It could do it as long as it dealt with capital problems of community groups providing those kinds of services.

Dr P. Berger: I will let Dr Frankford respond to that.

Mr Reville: I just wanted to make sure the committee realized that

is your view, because I do not think you have said that to us, although I see it here in the written brief.

Dr Frankford: Yes, I think that is exactly— I think there are many ways of providing other free-standing facilities. I would hope the aim would be to provide necessary services like abortion or birthing on a province-wide basis. There is no guarantee in the legislation that it is going to be planned on a province-wide basis. It seems to be very much at the discretion of the minister.

1430

Mr Reville: Or planned at all. The committee might also be interested to know that Dr. Frankford runs a health service organization in the east end of Toronto, which is one of the types of health care models that the government is finally beginning to encourage, and I think that is good.

Do you see the legislation as being a corollary to the government's chat about changing the emphasis of health care to more community care and more illness prevention, or not?

Dr Frankford: Presumably, the word "community" can come in, because I suppose these things can be outside hospitals, if that is one definition of community.

Mr Reville: It is a pretty narrow definition.

Dr Frankford: Right. But the thrust seems to be around procedures, and I am really surprised that is considered a priority at this stage. I think the procedures can be done in hospitals, and it can be argued whether money is saved or not.

Mr Reville: Right.

Hon Mrs Caplan: You do not see any opportunity in this act for a health service organization to provide additional services that could not presently be provided without extensive operational costs being required?

Dr Frankford: I think we would have hesitation about getting involved in something which would require applying for a licence with a five-year term, with the uncertainty as to what things are going to be allowed.

Hon Mrs Caplan: So you would never want to respond to a request for proposal that clearly stated what was being looked for.

Dr Frankford: The media always seem to say the thrust is to encourage outpatients for in vitro fertilization, cataracts and other procedures. I think it is diametrically opposite to the sort of thing which a community-based primary care facility would really want to get involved with. The way I read it seems to be that you would get proposals either from individual entrepreneurial doctors or from corporations.

Dr P. Berger: I guess one of the problems we see, and maybe Mrs Caplan could answer this, is that, let's say, community organizations or community physicians do respond to a request from the minister to apply for a licence for an independent health facility. Under section 23 you say, "Yes, but we're only going to fund the 75 per cent which is allowed under section 23." I think it is fairly clear the ministry can pay all or part of the costs



of a licensed independent health facility.

Where is the rest of the money going to come from to operate that organization? I guess our worry is, is cabinet then going to pass regulations allowing that licensed independent health facility to charge a facility fee, which in our view represents a user fee?

Hon Mrs Caplan: I am going to ask Bob MacMillan to respond to that.

Mr Reville: You keep doing this and it is not right. I do not mind your assisting the deputation with information, but when you start getting into these political speeches it really ticks me off.

The dilemma is that we are not going to see the regulations before this thing is law. The regulations will be as tall as I am, I am sure, and will have all sorts of power in them that we cannot even contemplate. You have identified some concerns you can think of already, and the ministry says those concerns are not founded, but we are not going to know until it is over. That is one of the dilemmas, for sure.

I think your presentation just blows the government's rhetoric away. I obviously understand why the government feels uncomfortable about that. Thank you.

The Chairman: Is there any reaction? There was not a question there, but it is your time, so do you wish to react?

Dr P. Berger: No. I would still be interested about that particular situation, because it was our greatest concern. If section 23 is applied, where only part of the costs are paid for, is it possible that a facility fee will be allowed under regulations, which again is classed as a user fee?

Hon Mrs Caplan: Mr Chairman, if it is acceptable, I would like Dr MacMillan to respond.

The Chairman: Sure.

Dr MacMillan: The reason that section is in there is, obviously in some cases independent health facilities will be licensed for a certain segment of their operation. For instance, a plastic surgeon may be licensed and will be paid everything for that which he is delivering as insured services, but he may be operating in the same room doing cosmetic surgery.

There is no question that the intent of this legislation has been to remove the burden of charges to patients, who are presently paying anywhere from \$150 to \$1,000 a crack for certain sophisticated services in the community. The intent is for the government to assume that task.

Mr Philip: That did not answer his question, though.

Dr P. Berger: We thought that was the intent. It did confuse us, if we took the example of a community organization, that it is possible it might not get—if we can use abortion clinics, which are now charging, there is one across the hall from my office and it charges, I do not know, \$150 to \$200 cash on top of what I suppose is billed through OHIP.

To us, that represents an impediment to a necessary service, but if you are telling me that for those types of services where it clearly is necessary

to ensure the services, the ministry will fund them completely and never introduce a facility with a fee which would be a user fee, then we are reassured and part of the reason we came here was to clarify it.

Hon Mrs Caplan: Subsection 3(3) is very clear that no person shall be charged for anything in respect to an insured service under this act. The intention of the section that you referred to was to allow for the situation where within the facility there was either an uninsured service or perhaps something funded by another ministry or unrelated to a health service, a social service. This bill is flexible enough to be able to provide services in alternative ways in alternative settings that previously have not been possible under any other piece of legislation.

Dr P. Berger: Of course I accept your word on that, but under the original draft it did have the caveat after subsection 3(3) of "except---

Hon Mrs Caplan: That is the reason that was removed so that there would not be any question. It was not the intent even in the first draft to have any individual being charged, so the act was clarified to make sure that subsection 3(3) dealt with that. The other section is response to the circumstance that was described.

Dr P. Berger: Okay, and I suppose that under clause 33(1)(1), you would exempt those independent health facilities that were serving dinner as part of their operating costs, after the cosmetic surgery? If that is the intent, I am reassured also.

Dr Frankford: I have been confused as to whether it is physicians who are being licensed or organizations which are being licensed, and what Dr MacMillan just said would seem to imply that part of a doctor's operation could be a licensed facility and part of it could not.

Hon Mrs Caplan: That was where the question came on the opportunity for health service organizations and community health centres which have a primary care component and would wish—and I have heard from a number that they would be quite interested—the opportunity within that structure to be able to provide additional services where the payment which is presently provided would not contemplate the operating overhead of that procedure.

Dr Frankford: If I can respond from my position in an HSO, any funding I would like to receive would be either program funding or per capita funding for particular providers or services, maybe, which I think is far more flexible and does not require applying for five-year licences.

Hon Mrs Caplan: Just for clarification, this contemplated the kind of surgicentre or the kind of ambulatory—which would really be a small operating room—where you would want to have the kind of quality assurance built in because the procedures that you were doing would be above and beyond what a normal physician's office would provide because of the costs associated with it. That is what this contemplates. It will certainly not attract or be attractive to all of those who are practising.

Dr Divinsky: It is procedure-oriented, it does not—unless you call psychotherapy or counselling procedures as well; those kinds of community-based social services that family physicians are more likely to be in need of and have funding for. I think that is what Dr Frankford is commenting on.

Hon Mrs Caplan: I understand.

The Chairman: Thank you very much for coming here today and giving us your perspective on the bill. I hope the exchange has been helpful in clarifying some of the issues.

The next delegation is the Association of Ontario Midwives. Representing that organization we have Eileen Hutton and Leslie Schear. Welcome to the committee. You have about half an hour for the presentation and we would appreciate if you would leave some of that time for questions.

1440

Ms Hutton: Certainly.

The Chairman: The choice is yours.

Ms Hutton: Actually, our presentation will probably be fairly brief. What we thought we would do is read through the document which has been handed out and then follow that up with specific questions.

The Chairman: That is fine.

#### ASSOCIATION OF ONTARIO MIDWIVES

Ms Hutton: The Association of Ontario Midwives Position Paper on the Independent Health Facilities Act:

The Association of Ontario Midwives has a number of concerns about whether the Independent Health Facilities Act fosters community-based health care. The Independent Health Facilities Act has as its stated goal "a move toward broader-based community health care,...while at the same time ensuring high quality, accessibility, safety and the best possible use of resources."

These are goals which the Association of Ontario Midwives, itself a group which grew out of a broad-based community grass-roots movement, strongly supports. However, it is our view that the government cannot develop community-based services using such legislation. We find ourselves in the position of agreement with the Ministry of Health on the objectives of Bill 147 but in strong disagreement over whether this legislation could ever achieve its goals. As well, we have a number of concerns about this legislation if it is intended to be the legislation under which out-of-hospital birthing centres are to be governed.

The Association of Ontario Midwives supports the stated intent of Bill 147. However, we have concerns with regard to how the legislation will provide community-based health care. In this paper we attempt to address the problems of community access in the processes suggested for setting up and maintaining an independent health facility as well as problems specific to the governing of out-of-hospital birthing centres under this act.

Out-of-hospital Birthing Centres: The Association of Ontario Midwives has always supported women's choices in childbirth, and we believe the widest variety of choices of settings for care in the reproductive year is optimal. Our organization supports in- and out-of-hospital birthing centres. The Minister of Health's announcement of government support for out-of-hospital birthing centres is a positive step.

We believe that Bill 147 in its present form would not govern a midwifery-based out-of-hospital birthing centre as the background information given on the act specifies that only insured medical services will be funded. We envision an out-of-hospital birth centre staffed by midwives. Such a facility would use hospital-based medical services only in the event of transport to hospital entailing partial or complete transfer of care from midwife to doctor. The Independent Health Facilities Act, as it is now written, would not seem to be the appropriate legislation to cover such a facility.

However, if it is the government's intent to legislate out-of-hospital birth centres under this bill, there are some issues which need to be addressed. The transfer of patient care to hospital will need to be dealt with to accommodate out-of-hospital birthing centres. A centre may need a formal affiliation with a hospital while remaining a fully functioning independent health facility. To accommodate the special needs of an out-of-hospital birth centre, we would advise that the restriction on overnight stay cited in the fact sheet on the legislation be waived and suggest that a 24-hour maximum post-natal stay be recommended.

**Suggested Services:** The services suggested as appropriate for the independent health facilities, such as laser technology and treatment of diseases of the eye and uterus, abortions, cataract surgery, radiology, fracture management, in vitro fertilization and heart and bladder investigations, are needed services but fundamental problems arise from the selection of such services as target services for independent health facilities. Some of these services may be more appropriately performed in hospitals. Others may be adequately provided for by physicians in the community and others may have been overlooked in the preliminary list of services.

Our concern is that this legislation be flexible enough to adapt to changing community needs and to different geographic and socioeconomic settings. But most important, the Ministry of Health has stated its intent to emphasize preventive care and health promotion. The Independent Health Facilities Act, in its selection of such intended services, does not emphasize such goals.

**Ms Schear: Practitioners:** The explanatory background information provided with the act states that only approved expenses associated with the provision of insured medical services in these facilities will be funded. Such a restriction could discourage the multidisciplinary approach which has been found to be successful in community health centres.

**Broad criteria for independent health facilities:** The mechanisms for making proposals concerning independent health facilities and the subsequent licensing of such facilities are problematic. Preference is given to nonprofit facilities and Canadian licensees, but for-profit non-Canadian-run facilities are a possibility under such legislation. This poses difficult ethical problems which can only be solved by the stated exclusion of such services.

**Licensing and needs assessment:** There are problems with the procedure the ministry proposes for ensuring community involvement. It is the intent of the legislation that the local district health councils will play a major role in defining community needs and making recommendations to the Ministry of Health, or interested applicants will approach their local health district council to discuss determination of the need for such a service in that specific locale.



District health councils serve large populations in sometimes very large geographic areas and are not always the appropriate mechanism for community input. Individuals or groups may be better served by being able to apply directly to the director of independent health facilities. We believe that community access needs to be ensured and that the issue of additional mechanisms for the processing of community proposals needs to be addressed in the legislation.

Continuing accountability: Monitoring the continuing quality of the independent health facility once it has been set up poses difficulties. The Minister of Health is responsible for appointing employees of the ministry or others as inspectors or assessors of the independent health facility.

Assessors will be physicians and will be primarily concerned with ensuring that patients are receiving quality care. Inspectors will be concerned with the physical facility and with ensuring that all health facilities comply with the provisions of the legislation. Assessors and inspectors are to be responsible to the minister and will play the major role in determining whether licences of independent health facilities will be continued or revoked. Doctors, as assessors, will only be competent to evaluate medical services.

Again, the problem of the independent health facilities with a wide variety of care givers arises. We believe it is only appropriate for physicians to assess services provided by other physicians. We also realize, from the very latest background information, that this has occurred to other people as well, but we feel it needs to be actually written within the act.

Hon Mrs Caplan: Are you aware of the amendment that has been proposed?

Ms Schear: No. We are not aware of it in that form.

The Chairman: Why do we not finish the delegation and then—

Ms Schear: As well, this mechanism for monitoring excludes community input, while it gives the ministry very broad powers. Even assuming that the licensing mechanism provided adequate community input, such community direction would seem to be lost in the process designed to monitor the continuing adequacy of services provided by an independent health facility.

There may need to be a role for community involvement before the suspension or renewal of licences for independent health facilities reaches the level of the appeals process.

The Chairman: We have some questions from committee members. However, the minister did ask for the attention of the committee to point out an amendment which was not sent to you as part of the package. You have now received that. Did you want to give them a brief explanation?

1450

Hon Mrs Caplan: That permits for the appointment of assessors by the officer of each of the colleges. When the midwifery college is established, a peer review assessor would be appointed. But that is pending, as you know, the establishment of midwifery as a formal profession. Until that time and until the completion of health professions legislation review, the role of physician would be a part of any birthing centre and of course subject to everything

that exists today.

Mr Carrothers: I wanted to go back over your first comments again; you said this would not really permit out-of-hospital birthing centres to take place. I think you were focusing on the words "insured service" there. I want to get an understanding, because it is not quite how I understood this act. Maybe your group could comment.

I thought the operative part of this legislation was section 23: "The minister may pay all or part of the cost of services provided" in a facility. I am wondering if the use of the term "insured service" is not part of a mechanism that is an enforcement against charging a facility fee, but services other than insured services could be paid for in one of these facilities.

I see some nodding. Maybe I should really be asking this of the ministry, as I am fumbling around trying to get my thoughts straight. The question is: Can services other than insured services be funded within one of these facilities?

Dr MacMillan: As you are aware, an insured service now does include, for the purposes of this act, a physician's service.

Ms Hutton: It is those services covered by OHIP.

Dr MacMillan: The only physician's services associated with maternity are the delivery fee, prenatal and post-natal care; the professional component for the physician. Once a licence is established, the act allows for the ministry to work out the funding needs under the auspices of that. So if there are nutritionists, midwives and nurses, whatever, involved on the staff in that special, unique role of a birthing centre, then the act allows the opportunity for working out the funding needs, which will include many professionals who now are not funded in the community, through the Health Insurance Act.

Hon Mrs Caplan: This act is permissive in being able to go beyond the traditional insured service to include the program, which would include health promotion, prevention and education opportunities, and allow for the funding of an independent health facility.

Ms Hutton: In what part of the act does that happen? In my reading of the act, I would see it as dealing specifically with those services that are currently funded under OHIP.

Hon Mrs Caplan: The ability to go out on a request for proposal as part of a program and then receive proposals from a variety of individuals, community groups and organizations in response to that, then allows for the negotiation of the funding of the facility, either on the basis—There are a number of bases determined with the course of the act. But that process of going out with a request for proposal and the flexibility this act allows, allows us to provide services in alternative locations with quality assurance. The framework for that is in this act. It is the request for proposal process.

Ms Hutton: I can understand you are saying then, in that respect, that the act is permissive in that you can expand it beyond those payments to strictly physician services. How would you see it acting in a setting where you had a full midwife-run birthing centre, for example?

Hon Mrs Caplan: That would not be permitted today, because midwives

do not have a scope of practice, nor are they a recognized profession. In fact, those are the discussions that will require the determination of the health professions legislation review process. However, this act refers to practitioners as well as to physicians, so the act again is permissive in that, should the other piece of legislation result, then the act could accommodate that eventuality. It is premature today to contemplate what might evolve from another review process.

Ms Hutton: In reading through the act, I have some confusion. If you see the act as being more expansive or broader than strictly dealing with physician reimbursement, then how do you limit the act to not cover things like other services that are partially paid, chiropractic sorts of clinics where they are doing outpatient care on an ongoing basis, if you wanted to put it in that context? There is any number of physiotherapy clinics where in fact they are treating individuals, but I would not see that falling under this type of—

Hon Mrs Caplan: The act permits exemption by regulation. We had the chiropractors here yesterday. The answer I gave them was for exactly the situation you have identified; that is, that the intention is to exempt by regulation the private chiropractic practice. However, in a proposal, if chiropractic services were a part of an independent health facility, they would be fully covered and no facility fee would be charged. That would be negotiated and fully paid for by government. That is the intent of this act and the flexibility it allows. It allows what is existing today to be exempted by regulation.

Ms Hutton: The sense I get from what you are saying is that you feel it is the intent of this legislation to cover birthing centres.

Hon Mrs Caplan: In fact, that has been announced. The ministry policy had always been, as you know, in-hospital. With this act, and as you know there are other jurisdictions where there are licensed birthing centres, we can have the kind of quality assurance, negotiated types of standards, backup and so forth, and the opportunity to negotiate a funding arrangement with a health professional team that presently just does not exist today under existing legislation. We have announced that following proclamation of this act the first request for proposal will be for three pilot birthing centres.

Ms Hutton: Yes, I am aware of that.

There are a couple of concerns, then, that we are left to deal with. You can clearly see this act as either working to open things up for facilities such as birthing centres and/or to be more controlling. I am wondering whether communities will in fact have as much say in terms of voicing their needs or concerns about developing those kinds of care centres.

Hon Mrs Caplan: Mr Chairman, I do not want to take too much time. It is a specific question on process and I will try to be concise.

The Chairman: Then I would like to finish Mr Carrothers and on to Mr Philip.

Hon Mrs Caplan: The intent is to facilitate the planned and orderly development of community-based services, to allow the district health councils to identify a need and recommend to the minister a call for a request for proposal, or to allow the minister to identify a need, consult with the district health councils to get their advice and then proceed, if appropriate,

to call for request for proposal. That is the intent of the act. It is the orderly legislative framework to plan and fund with a quality assurance which does not exist today outside of hospitals.

Ms Hutton: Our concern, which is fairly clearly stated in the paper, is that we wonder whether that is responsive enough to community needs.

The Chairman: Your point has been made. Mr Carrothers, do you have any other questions?

Mr Carrothers: She asked all the questions I was going to ask, so I pass.

Mr Philip: I just have two questions arising out of your brief. I hope the minister will address herself to the one on the bottom of page 1. Do I take it from that that there is some regulation contemplated that will put in the 24-hour provision? That 24-hour provision would directly affect the service which birthing centres can provide. I would ask the minister what her response is. Why have such a regulation? If, on one hand, she is announcing her support for such centres, why have a regulation that would inhibit them from doing their job?

Hon Mrs Caplan: The intention of the legislation is to foster community-based, ambulatory outpatient and the kind of procedures where you are not inpatient. All of the advice we have is that birthing centres can be accommodated within this legislation and that the 24-hour provision is not a problem and can be dealt with as a term of the licence, for observation and so forth.

Mr Philip: But they are indicating it is a problem and I would like to hear from them.

Ms Schear: I think it potentially is a real problem.

Hon Mrs Caplan: Bob, do you want to comment?

1500

Mr Philip: May we hear from them? I am perfectly happy to hear from the ministry, but I would like to hear what they see as the problem.

Ms Schear: I think our concern is that the average first-time labour lasts about 24 hours. It is quite conceivable that a woman in labour could be labouring for that amount of time and then you have not begun post-natal care at the 24-hour cutoff period. That is why our alternate recommendation is that the 24 hours begin after the birth of the baby, rather than before, so that you do not set a time clock on labour; that is our concern.

Hon Mrs Caplan: The advice I have is that those are the kinds of operational details which would be set out in the terms of the licence and that this act would accommodate birthing centres.

Mr Philip: My second question, which the ministry may want to respond to, arises out of the anxiety expressed on the bottom on page 2 of the brief. It says, "We believe that community access needs to be ensured and that the issue of additional mechanisms for the processing of community proposals needs to be addressed in the legislation."



My question to the ministry is this: Supposing there is a need, and supposing the local district health council manages to be influenced or perhaps even taken over by some group that may have a particular point of view—and lobby groups and various types of groups do manage, in some places, to take over hospital boards, community health councils and a variety of other things, for whatever reason, for their own agenda, and I do not dispute their having a right to follow their own agendas—what happens when there is a legitimate community need? Does the ministry see a kind of overriding provision and appeal provision whereby a group like this, which may not be supported by the local health council, can at least have its proposals considered?

Hon Mrs Caplan: District health councils are advisory to the minister; they have no statutory or legislative authority. There is no intention, for purposes of accountability, to enshrine in legislation—They are, I would repeat again, advisory to the minister. The minister stands accountable for the decisions that are taken, and I believe that is appropriate. It is very clear that the role of the district health council will be set out by regulation. It is, again, not statutory in this piece of legislation. Being an advisory body, where its advice is not deemed appropriate the minister has full authority to act in the public interest.

Mr Philip: We have had some incidents in some provinces, more than in Ontario, where certain groups have used their political muscle for their own ends. You can see the ministry overriding that kind of situation.

Hon Mrs Caplan: Yes.

Ms Hosek: You have partly answered my question. I was interested in the 24-hour maximum post-natal stay question.

The other concern I have is one that was also mentioned by the minister. I would personally be extremely happy to see midwifery as a recognized profession—I think it is long overdue—and very much want to see birthing centres run by midwives. I am probably one of the people, along with you and some other people in this province, waiting for the health professions legislation review to be out there so that that can happen.

My only other concern has to do with your sense of where in the province the provision of midwifery care might make the most difference, given that health facilities and services are unevenly available. If you were to pick right now, just from your knowledge of what is going on in the province, where the needs would be the greatest, would you be able to pick a place, or is that an unfair question to ask you?

Ms Schear: I think the north is clearly a very underserved area and that is true in midwifery and in a number of other fields. In most of what we have written, we have expressed our concern about getting better services in the north.

Ms Hutton: Certainly in a number of the more rural, even southern communities, at the health conference that was held two years ago, the southwestern Ontario groups made presentations stating that basically their family practitioners are retiring and their women are being left without care without travelling long distances. I think many of the rural communities as well may be well served by midwifery services.

Ms Hosek: Are you saying that there used to be, at least in some of

the rural areas, a level of more informal birthing care that is disappearing and that midwives could in some way replace it?

Ms Hutton: I do not know that we could replace it, but we could certainly provide an alternative to those women to travelling long distances to have their babies.

The Chairman: Are there any further questions from committee members? If not, as chairman I want to thank you on behalf of the committee for your presentation, for taking the time to come here and share your views with us. I think the exchange has helped us to understand your perspective and get some points clarified.

The National Action Committee on the Status of Women has cancelled its appearance.

Mr Carrothers: Are we going to take a brief break to warm up?

Hon Mrs Caplan: I was trying the hot air.

The Chairman: We can. However, is Carnelian Health Services here? They are here and ready to go, so why do we not just move along. If you want to get up and run around the room a couple of times—

Mr Carrothers: The minister has indicated she has been trying desperately to warm the room up, so I will let her continue.

#### CARNELIAN HEALTH SERVICES CO-OPERATIVE INC

The Chairman: Our next delegation is the Carnelian Health Services Co-operative Inc. Representing that organization are Ms Bonnie Burgess, director, Ms Sandi Eggleton, director, and Ms Margaret Shaw, director. Welcome to the committee. We have allocated approximately 15 minutes for your presentation. We would also like the opportunity to ask you some questions within that time. As you can see, we are starting a bit before your scheduled time, so proceed.

Ms Burgess: Good afternoon. My name is Bonnie Burgess. We are grateful to have the opportunity to present our opinions on the Independent Health Facilities Act this afternoon.

Our brief, as you can see, is very short, sweet and to the point. There are lots of things we have left out, purposely, because they have been covered by other organizations in dissecting the act. The Medical Reform Group of Ontario, Ontario Coalition for Abortion Clinics, Canadian Abortion Rights Action League and various organizations, in our view, have presented our points succinctly.

We are directors of Carnelian Health Services Co-operative Inc, which founded Woman's Choice Health Clinic, Toronto's newest free-standing abortion clinic. We were drawn together for this project due to the compelling need of women for abortion and related services within the province.

Carnelian is incorporated as a nonprofit worker co-operative. We chose this model in an attempt to eliminate the power imbalances that are innate within a hierarchy and to redress its implications for women both receiving and providing health care.

It was necessary for the co-operative to rely on several sources of funding. One co-op member, a physician, secured lines of credit, two founding members secured personal loans on behalf of the clinic and the corporation itself secured a corporate loan. These sources of financing were unfortunately necessary because capital and operating funds were not available from the Ministry of Health.

In December 1988, the physician assumed control and excluded the other members from further participation in the clinic. We are now in litigation in order to resolve this matter.

We are bringing this to your attention because the effects are farther-reaching than simply our own personal circumstance. Because the existing health care system does not allow for funding projects such as ours, we were compelled to enter into a financial arrangement with the only person who had access to the moneys needed, the physician.

It is important that the government recognize the changing values in society regarding improved models of health care delivery. It is crucial that any piece of legislation reflect those values, which are moving towards community-based, consumer-directed services with an expanded role for nonmedical health care workers. This is a change from the old model of strictly doctor-run facilities. It is not clear to us how the proposed Independent Health Facilities Act will deal with more progressive models. Will it simply reflect the status quo as it is? There are skilled, committed health care workers who are willing to provide these services and consumers who are demanding participation in the kind of care they receive.

#### 1510

The economic power to provide services continues to lie solely in the hands of an élite few in the case of health care facilities, namely, doctors and hospitals. This is extremely limiting to real participation of nonmedical health care workers and for consumers.

Our situation is an example of exactly what can happen when the funding is not available to groups other than doctors and hospitals. The Independent Health Facilities Act could provide for an opportunity for the government to shift the health care system from doctor-hospital to community-based, deinstitutionalized, demedicalized health care.

The Ministry of Health should provide support for innovative health care initiatives that are undertaken by nonmedical professionals. A community-based model provides for cost-effectiveness, more participation of consumers through community boards, and better working conditions for health care workers through more direct participation in their working environment. "Community-based" must mean nonprofit and without a doctor in charge. Doctors should be hired on a contract basis and their wages salaried.

The Independent Health Facilities Act has failed to deal with the huge wage discrepancies between doctors and other health care workers that affect inequalities in working conditions and drive up the cost of service.

On the third page, you can see the summary of what we view as being the most critical points in the Independent Health Facilities Act. At this point, we cannot say that we support the implementation of the proposed act, in its present form.



We support the critique by the Ontario Coalition for Abortion Clinics of the proposed act and its recommendations. We also support the Toronto Birth Centre Inc as well, and the Canadian Abortion Rights Action League.

Our own recommendations and concerns with the proposed act are that any piece of legislation must stress the following:

1. Facilities must be Canadian-owned and nonprofit. There simply cannot be a preference for nonprofit; they must be and they must be Canadian.

2. Assurances of quality of care must be addressed, and more specifically, facilities must (a) elect community boards to promote consumer participation and this will also help to ensure a nonjudgemental approach and atmosphere for women who are receiving these services; (b) be feminist-run and woman-centred; and (c) provide a comprehensive range of services in addition to abortion services.

3. Our third point is brought home to us in our example. In our experience, because working environment is related so closely to quality of care provided, any legislation must include recommendations from unions and organized labour before its enactment. I think you heard the Ontario Nurses' Association position put forward today. As a registered nurse, I can tell you that what ONA is talking about possibly happening in independent health facilities has already in fact happened in our situation: there are no measures to deal with disputes.

4. The capital and operating funds must be available from the Ministry of Health for innovative projects that meet the above criteria.

The Chairman: Thank you for your presentation. I note that during your presentation, you made reference to a matter that is in dispute and could possibly be before the courts. I simply caution committee members and yourselves not to get into the details of that matter, but rather to confine discussion questions to the act which is before the committee.

Ms Burgess: That is right.

The Chairman: I have three members of the committee who indicated a desire to ask questions, beginning with Mr Carrothers.

Mr Carrothers: Your situation raises some interesting problems. I think you were here for the previous discussion. I guess I want to start first with your comments about nondoctor-based facilities. If I have understood the discussion we have just had, this legislation does not prevent a facility from being funded that would provide services other than those provided by doctors, and that the type of capital you were looking for that seems to have caused your trouble because of the loans would indeed be able to be flowed through this legislation, if I have understood correctly.

Perhaps what is intriguing to me—maybe I should direct my question to the ministry—has to do with this question of the breakdown of the working relationship between the groups that started. How would the ministry be able to respond to a breakdown like this once an operation was started? Obviously, there has been some sort of irreconcilable difference—could I use that term?—that has come up between the groups that started this. What would happen in that case, in a facility licensed here?



Hon Mrs Caplan: It is very difficult to comment on any specific case and I would not attempt to, especially since I understand this matter is before the courts. My understanding of how this legislation works is that those kinds of details and understandings would be very clear as to the relationship and accountability as part of the proposal call. The corporate structure would be identified if there was one, the status of the organization applying, whether it was nonprofit charitable or just nonprofit, and whether it was a sponsoring organization, whether it was an individual. The request for proposal contemplates any one of a number of different structures.

It is important to note that the organization, individual or corporation is the one that enters into a relationship with the ministry to deliver the services in an independent health facility, and the terms of the licence, I think, would answer most of the questions and possibly avoid the kind of difficulties afterwards by having it clear in the terms of the licence. Gil, do you have any comment on that?

Mr Sharpe: I was just going to say that if a partnership, for example, applies for the licence, one would hope the partnership agreement would deal with matters of disagreement and so on. The corporate structure itself would depend on the nature of the corporation, but again, within that structure one would hope there would be a methodology to deal with aggrieved individuals who are part of the corporation.

We deal extensively in this bill with the question of controlling interest in the corporation. Share transfers and so on are very carefully monitored. Jim Spence, who is an expert in this area of law, briefed the committee the first day and will be back with us for clause-by-clause to explain in some detail how that would operate. I would hope that within the context of the bill, and ultimately the review of the submissions that come in and the legal structure of those who are submitting proposals, we would be able to address concerns such as this.

Mr Carrothers: While you are still there, if I have understood this, a group could start one of these facilities and employ the physician. This does not have to be run by the physician.

Mr Sharpe: Exactly.

Hon Mrs Caplan: Under this legislation, anyone, any group, any organization, any corporate structure could apply.

Mr Carrothers: I would maybe like some comment from the witnesses. It seems that the capital would be available under this legislation to do what you have done, if that was the key to the problem, because—

Ms Burgess: I am not sure. Am I hearing a commitment from the minister that abortion care services will be?

Mr Carrothers: We were talking just in general about facilities, that capital could flow to a facility that was not operated by a physician, which I thought was the generic problem you were raising. Does that allay the situation or the fears you have?

Ms Burgess: If the commitment is that regardless of the political implications of what that service may be, funding will be available to all alternative and nonmedical practitioners who wish to start up health care

initiatives, if the commitment is to give capital funding for those initiatives, then we are somewhat relieved by hearing that, yes.

Our concern is that if there is no structural change, it does not matter what the model is that is put out for health care. If the funding continues to be given to an élite group, ie, physicians or hospitals, and the economic clout remains there and also the burden for the private practice, the clinic or whatever rests with the physician, there is not any compelling need for physicians then to direct their care to community-based programs, if they feel they are going to be burdened with onerous loans and so forth in undertaking the initiative.

But if what you are saying is that there will be capital funding for nonmedical people, then that will relieve physicians, and if you are going to be relieving physicians and giving alternative organizations the opportunity, then that does make structural changes.

1520

Hon Mrs Caplan: Could I clarify this? This is framework legislation to permit the expansion of community-based facilities and services. It is service-oriented. It deals today with any insured service that can be safely and appropriately provided in an alternative setting to a hospital. It is contemplated and very clear in this act that preference will be given to Canadian nonprofit corporate structures and organizations.

However, any group, organization or individual can apply. The reason for the five-year term was to permit the calculation for those kinds of pieces of equipment that would not normally be found in a physician's office and the expense for which would be amortized over a five-year period to meet that kind of overhead expense. That is the contemplation of the facility fee, which is available, as I said, to any individual, any practitioner, any group or any organization, and preference will be given to nonprofit organizations.

Is that clear?

Ms Eggleton: May I ask you a question back? Is there an operational definition for the word "preference"?

Hon Mrs Caplan: I will give that to the legal experts.

Mr Sharpe: All things being equal on the submissions, if the proposal is from a Canadian resident and if the proposal is not for profit, that will be the successful candidate, all other things being equal: quality of care programs, funding base, procedures, etc. On balance, if everything else more or less equals out, these two categories will determine the victor in the competition.

Hon Mrs Caplan: The proposals will be judged on the basis of the merit of the proposals.

Mr Reville: The principles you espouse, the nonhierarchical, nonsexist, community-accountable health service delivery model, are supportable. In theory, I do not think this legislation is biased to any particular structural model. I think in practice most of the proposals will come from what you call élite, or what others might call more traditional models, with the doctor at the top and people below.

I assume that the model you have developed and in fact had operating was a collective approach that did not require a doctor to be the executive director. Is that correct?

Ms Burgess: That is right.

Mr Reville: You also proposed that women's health services be comprehensive. Is it your view that all those services could be provided in the nonhierarchical model you advanced?

Ms Burgess: Oh, most definitely. In our view, were we to have thought otherwise, we would have initiated a project that would have been different. But our view is that, yes, women's health care services can be rendered by nonmedical people in nonhierarchical settings and have benefits to both the women who are receiving the services and the women who are providing those services, because in fact women will be the ones who provide them as well.

Mr Reville: What we do not know is whether or not a district health council, a given one, all or any, will say, "We need comprehensive women's health services."

Ms Burgess: That is right. Remember, abortion will be included under that.

Mr Reville: Even if they do say it, you do not know when the minister will issue a proposal call, and if she does, we do not know whether he or she will fund any proposals. That is the dilemma, it seems to me.

Interjection.

Mr Reville: I should wait and see, shouldn't I? The dilemma, Mrs Smith, is that the government has not done this. That is why we have three free-standing abortion clinics in this city that were developed by these people and others, because the government refused to act.

Ms Burgess: Yes, and I think it needs to be made really clear that we would hate to see the dispute that has occurred among the founding members and directors of Carnelian Health Services be used in any way to limit access to abortion by saying that free-standing clinics are having these legal disputes and therefore you should not be opening them up. That is a separate issue. That dispute is between the directors.

We are completely supportive of women's right to access to abortion in this province and that is why this clinic was founded. It was the compelling need for abortion services, and because abortion services are not being provided in the numbers and the deinstitutionalized ways that we see as beneficial to women providing the care and receiving the care, we took the initiative to do this. What we are running into is a social problem because the health care system does not have the provisions for alternative groups like ours or any other alternative groups.

This is why, when you are giving your answers, I am listening but I am not sure what I am hearing, because if there are going to be structural changes with this act that will allow for really innovative initiatives, then that is a really positive step forward.

Mr Reville: Basically you ran into a social, political and economic problem in providing the service the way you wanted to.



Ms Burgess: That is right. Groups need the economic clout to be able to carry through with their proposals and to implement them. This would have worked if the funding were there.

Mr Reville: Mr Chairman, I just want to thank them for the sensitive way in which they presented an issue about which I know they all care very deeply and over which they are quite disappointed—I know that, too—that it did not work. The point they make that they remain committed to making sure women have access to abortion services is one of the key points.

Ms Burgess: Very definitely.

Mr Reville: The other key point is that they see a nonhierarchical, nonsexist delivery model, which I also commend.

Mrs E. J. Smith: Just following up on this, I also want to thank you for your presentation. It was very interesting. However, I am glad you were here for the presentation before yours, which was from the midwifery group, because I note in your summary, and I would think you agree, that your summary really addresses only one facet of independent health facilities, namely, abortions, and your concerns, for instance, that they become less (inaudible) woman-created, would apply only in the narrow scope. I think you would agree with that.

The minister has made clear this is a framework that is supposed to cover all kinds of fields. Maybe up north in remote areas removal of cataracts or eye disease, which is common among some of our native people, might be the more pressing need in some instances.

With that in mind, I would just ask you if you have read the proposal the minister made for birthing centres which was presented in the House before the House adjourned. Have you seen that one? I am sure you heard it mentioned in the previous presentation.

Ms Burgess: Have we read the minister's proposal?

Mrs E. J. Smith: The minister's statement on this, yes.

Ms Burgess: No.

Mrs E. J. Smith: I would really recommend to you that you read that. Mr Reville quite legitimately says this is a framework; how do we know it is going to happen? I would recommend that you read that so that you can get some sense of what the minister hopes will happen, because she has stated very clearly in there how she hopes the birthing groups will take hold of the legislation to fund independent facilities that serve particular needs. It is a particularization of the bill, you might say, which really envisions using independent health facility legislation in order to start particular groups serving particular needs more directly related to it. In this case, midwifery would be one of them. I hope that you will understand this is a framework and it is up to people like yourselves to take advantage of the framework.

Ms Shaw: I guess I have not heard anything that specifically addresses access to abortion, and that is what we are talking about.

Mrs E. J. Smith: Yes, okay. I hope you will understand the fluidity of the act and the intentions found expression in that.



Ms Burgess: I guess the concern is that the regulations are not there and without the regulations it is very difficult to know just what will and will not be done with this act. That is the concern. You are hearing that concern from every group that is coming before you.

Mrs E. J. Smith: Yes.

Ms Burgess: It is our understanding that legislation very rarely comes with regulations, but in this instance, with this act, if it is going to be that innovative, if it is going to be that forward-looking, then we are hoping the regulations will be there prior to the enactment.

The Chairman: Perhaps we could get the point clarified by the minister as to what extent we will know at least the general thrust of the regulations at the time we deal with the clause-by-clause.

Hon Mrs Caplan: The ability to start working on and the drafting of regulations is something Gil Sharpe has carriage of and he can give you some idea.

1530

Mr Sharpe: The problem is there are some regulations that we hope to bring before the committee. We gave an undertaking to show a list of the proposed exemptions to some of the professional groups that came forward. But the nature of regulations, being the implementation of the thrust of the statutory provisions, really have to await final determination by this committee and the Legislature as to what the final version of the legislation will be. We have a number of proposed government motions to amend the bill. There may be others that carry, but it would be premature to begin attempting to draft regulations until we know what we are dealing with.

Mrs E. J. Smith: It seems to me too that one of the important things about whether things are in legislation or in regulations is to allow for ongoing change. It has been pointed out repeatedly here in these meetings that other health acts are under reform, such as the Health Disciplines Act. If we get too rigid regulations now that do not take into account what changes may occur in those acts, we have actually done the reverse to what you are hoping. The regulations will be addressing existing acts, whereas we would like to see it so that ongoing changes and reforms can occur.

Mrs Cunningham: I do not share the response there, the optimism of the group around regulations, not at all. I have certainly seen regulations, at least the framework of them in the past, and have been able, through input from the public, to watch changes. That is exactly what has happened to this bill. I mean, you sent the bill out and you got a lot of input in the meantime. Now we have a better bill to look at. You could be doing the same approach for the regulations. There are certainly parts of them that the public is interested in, which it has drawn to our attention. That is just the statement I am making. There is no excuse for not having a framework. If anybody wants to respond to it, I would not mind hearing from them.

Mr Fleet: That might be suggested in the regulatory reform report.

Mrs Cunningham: I do not care. We asked for regulations and we were told that the hope was that they would be here during the committee hearings. I am not particularly interested in letting the government get off the hook on that.

Hon Mrs Caplan: It might be helpful for the committee to know, since the drafting of regulations and the practice has been in the ministry that the regulatory process as well has been a consultative one, that this is the ongoing intent. Once you have the framework legislation, there is the opportunity to make sure that the interests who will be affected by regulations are consulted.

Mrs Cunningham: That is fine, and that they may in fact be in committee if necessary.

Hon Mrs Caplan: In fact, there is a regulations committee which reviews all of the proposed regulations before they are approved by cabinet.

Mrs Cunningham: Am I on that committee?

Hon Mrs Caplan: No.

Mrs Cunningham: Would these people be able to speak to the committee?

Hon Mrs Caplan: Yes, I believe the committee allows for some representation.

Mrs Cunningham: I could be representing somebody?

Hon Mrs Caplan: It depends if you were part of an organization. As a member of the Legislature, you have a slightly different status. I know that the regulations committee will frequently ask proponents to appear to discuss—

Mrs Cunningham: Just a point. I think the committee is well versed in the fact that it could be giving some interesting, objective and supportive arguments to improve legislation, as we are now, and of course the regulations that go with it. I am just questioning the process.

Hon Mrs Caplan: Can I try and clarify a fact on the record?

The Chairman: Just a minute. Mr Philips had a point to make.

Hon Mrs Caplan: I made an error in what I said. I would like to correct the record.

Mr Philip: I just did not want Mr Fleet's argument to go amiss and since he is not a member of the cabinet, maybe the minister might consider that with all of these complementary pieces of legislation coming through with the very complicated regulatory system, it might be nice if the cabinet did seriously consider the recommendations of the committee that the member for High Park-Swansea (Mr Fleet) chaired. It makes some excellent recommendations and I think if we adopted that particular report as a working model for this Legislature, then some of these problems would be resolved.

The Chairman: The minister wanted to correct a point and then we will get back to Mrs Cunningham's question.

Hon Mrs Caplan: I am aware that when regulations have been drafted the regulatory colleges of the professional organizations are regularly invited to the regulations committee. I am not familiar and I do not believe that in fact organizations and associations other than regulatory colleges appear on any kind of regular basis.

Mr Fleet: I think that is correct.

Hon Mrs Caplan: That is correct. I know the colleges do appear because they have an interest in enforcement of regulations as they relate to professional organizations. They also have the power to make regulations, so that they will meet with the regulations committee to discuss a regulatory-making aspect.

Mrs Cunningham: Which does not offer us any happy feeling.

The Chairman: Did you have some questions to ask the delegation?

Mrs Cunningham: Yes, I did.

Mr Fleet: Always trying to make you happy, Dianne.

Mrs Cunningham: You keep working on getting your report implemented, David, and we will be a lot happier if you do.

Yes, I have a couple of questions. Given the responses that you had around capital, as a nonprofit group, what do you think you could do in order to raise the capital, given the responses you got today? Those were different, by the way, from what I thought I heard yesterday, but we can deal with that later.

Ms Shaw: I did not hear the question, because of the hoopla going on.

Mrs Cunningham: Given the responses you had to your questions to the government about capital dollars—you were the ones who asked; I was listening—what would be your understanding as to how you would get the capital funding if you were to try to re-establish your clinic under this particular bill?

Ms Burgess: If I heard correctly—if anyone else heard differently—we would be covered. We would apply for the capital funding and as an alternative health care model we would be as entitled as anyone else to secure that funding.

Mrs Cunningham: That is what I heard too.

Hon Mrs Caplan: What is contemplated by the five-year licence and the component for operating funds is the ability of the licensee, as part of the request for proposal, either to receive as part of the operating dollars or to be able to use that five-year licence as collateral at a bank, to be able to finance the operation. Gil, do you just want to explain that any further? That is what is contemplated.

Mr Sharpe: Just to say that the mechanisms at various clinics will use to capitalize the operation will vary, depending on the nature of the proposal, the geographical location, the nature of the services and the funds available and so on. So it may be, for example, that a particular proposer will have to rely on government funding for capital. It may be that someone else will be leasing premises and any improvements in terms of leasehold improvements will be negotiated with the landlord based on, say, a five-year commitment for a lease, and the only investment will be some equipment which can be depreciated. Or it may be necessary to look to the ministry for capital funding. I think the notion in the bill is that it is flexible enough to provide for a variety of financial arrangements depending on a number of different factors.



Ms Burgess: I guess the key to that is that this all relies on whether there is a call for a proposal. There has not been, in our view, any attempt by the government to date to be really innovative in the area of abortion care services. If we were to wait for the government to call for a proposal, I guess our feeling is that we would be waiting an awfully long time.

Mr Reville made the point that we took this initiative because nothing was happening. I do not see that anything has changed in that regard, that abortion care services are being provided differently or that there is any intent. If there is an intent, then we do not know about it. I think we would like to hear from the minister if the ministry is going to be looking at free-standing abortion clinics as an alternative method of providing abortion care services for women in this province. You are saying that you will call, but what are you going to be calling for? I do not hear you saying you are going to be calling for free-standing abortion clinics.

Hon Mrs Caplan: I have said clearly, and I would be happy to send you copies of previous statements that have been made on the provision of women's health services, that our approach is that women's health services should be provided in comprehensive women's health centres.

1540

We have, in fact, requested proposals for in-hospital women's health centres and have funded women's health centres on an in-hospital basis. Following, I believe the four women's health centres that were established, we said that any further ones we would prefer to have on a community-based approach as opposed to any further in-hospital.

Our approach is in fact not a single-procedure-specific, free-standing abortion only. Our approach has been, and it remains consistent, that women's health needs should be part of a comprehensive provision of women's health services and that policy stands.

We believe that reproductive care is only one component of women's health needs and as we identify and determine appropriate delivery and needs assessment, whether that is by district health councils or by the ministry, we then move to provide those services as we did when we went with the proposal for in-hospital services.

I think it is important to state once again that this bill is not procedure-specific. This bill is framework legislation to provide for any service which can be provided safely in a quality assured environment as part of a program in a community-based setting to be properly planned, to have its needs determined, to have a consultation with the district health council and then to be able to go with a request for proposal to make sure that you have the service provided in a quality assured environment.

Mrs Cunningham: Given the response, I would suggest that my interpretation of what the minister just said fits in with item 2(c) on your summary. The facilities in fact must provide a comprehensive range of services in addition to abortion services. Would I be correct?

Hon Mrs Caplan: The approach that we are taking—

Mrs Cunningham: That is what you just said.

Hon Mrs Caplan: —is for comprehensive women's health. That is correct.



Mrs Cunningham: In addition to abortion services.

Hon Mrs Caplan: Some of our women's health centres provide abortion services; some do not.

Mrs Cunningham: So, although the minister did not say the word "abortion" I think that she supports—

Hon Mrs Caplan: I did.

Mrs Cunningham: Did you? Just now?

Hon Mrs Caplan: Yes, twice.

Mrs Cunningham: My apologies.

Then you are fitting into at least the philosophy. I am not convinced you will be very successful in the capital part only because many of us have been involved in trying to get capital. It is a very hard thing to do, especially if you are up against proposals where they can be part of an existing facility already. If you are looking for something that is free-standing, it may be a more difficult thing to do. Free-standing to me is separate from a hospital or separate from a health facility? Is it that to you?

Hon Mrs Caplan: Yes, nonhospital based or nonhospital affiliated as well.

Mrs E. J. Smith: That is what the whole bill is.

The Chairman: Order, please. Mrs Cunningham has the floor.

Mrs Cunningham: Just so no one misunderstands, separate from a hospital is something that we have already discussed with the ministry and if the hospital, in fact, can make proposals—and we will hear from them tomorrow—their facilities may or may not be—I do not know how you separate from a hospital when hospitals now are running parts of their services out in the community, which I think is a good thing. Separate from a hospital is something we can discuss at another time. I am not sure whether we want to take the time of this particular group, but it is certainly an issue.

The Chairman: Why do you not proceed with the question you were going to ask, because we do have another delegation to get on to.

Mrs Cunningham: The question has to do with not being able to charge facility fees. I do not know what your interpretation of facility fees is, but if your nonprofit-making board did have an investment, would you expect to pay back the capital that you raised? You would certainly have to pay the rent if you did not have to raise capital. You would probably have to raise some capital even if you were renting. How would you get the rent back if you could not charge a facility fee? What would you do? How would you get the capital back if you could not charge a facility fee? I am just wondering why you did not speak to this. Is your interpretation of facilities fees different from mine?

Ms Burgess: My understanding is that the way things are right now, if a clinic charges a patient anything outside of what is deemed to be given by the government under insured services, it is a facility fee. In the specific case of an abortion clinic, my understanding is that the moneys we

had to charge women because the funding is not available would be a facility fee. The only way to recoup that, to keep that clinic running, would be to continue to charge women or go to alternative sources of funding.

Mrs Cunningham: Perhaps the minister could picture this dilemma and help us just a little.

The Chairman: I think we have been over this point, but if—

Hon Mrs Caplan: This act will not permit the charging of a facility fee to any patient. In fact, it contemplates as part of the request for proposal process, the negotiating of payment for the cost of operation and the amortization of equipment capital—that sort of thing.

Mrs Cunningham: That would be a direct grant from the government?

Hon Mrs Caplan: Rent, whatever—and that is what we are negotiating following the request for proposal, so there will not be any charge to a patient receiving an insured service anywhere in this province and particularly in a facility which is now providing a service formerly available only in-hospital because of the need to have an overhead cost.

Hospitals are funded by a global budget, plus the physician fee-for-service component for the professional fee. In doctors' offices, doctors receive their funding strictly from the fee-for-service for the professional fee, or through capitation in the health service organization, or salary or sessional fee in the community health centre, or a different model in the teaching hospital. Those are the sorts of remuneration.

There is no way right now, outside of those two places for service delivery, to be able to fund the facility fee or the operational and equipment cost which would go far beyond what a physician would normally do in his office and was today only really possible in a hospital environment but, because of the advances of new technology, can now be provided in a third setting, which we believe should have the same quality assurance you presently have in a hospital.

The Chairman: We are well over the time limit you were originally given. I think it has been a good exchange. Thank you for coming and sharing your views with us. Hopefully, some of the aspects of the bill have been clarified as well.

Our next delegation is the Ontario Medical Association, Toronto district. Representing that organization is Dr Joseph Berger, the chairman. Welcome to the committee. You have half an hour, Dr Berger, and I am sure you will save some of that time for questions from committee members.

Perhaps we could get a question answered here which the minister has put to me. Are you here on behalf of the Toronto district Ontario Medical Association or as an individual?

Dr J. Berger: I am here as an individual. I am also the chairman of the Metro Toronto district. I am not here as a representative of the Ontario Medical Association. I was going to clarify it myself, but thank you for asking.

## JOSEPH BERGER

Dr. J. Berger: Three years ago I addressed this committee as myself, Joseph Berger, a doctor speaking as an individual physician in opposition to Bill 94, what has come to be known as the health care inaccessibility act. Today, I have the honour and privilege of addressing you as an individual physician who is also chairman of the Metro Toronto district of the Ontario Medical Association, which is the largest district, representing nearly 7,000 doctors in this province.

I recognize that you have now sat through many presentations, including a formal one from the Ontario Medical Association, and perhaps my presentation comes appropriately now towards the end of your hearings as you orient your thoughts towards the future.

I am here today to ask you to think of the future, to think of the legacy you will be leaving to your children and grandchildren and to all the citizens who live in this province and will be living in this province over the next 30 or 40 years, because if you really care about health care in this province, not just now but in 10, 20, 30 and 40 years' time, then you will drop this disastrous bill. You do not need a bill and it has never been necessary to have a bill to inspire innovative and creative physicians to bring new techniques, treatments and procedures to the public. Bills to license only restrict, they do not create. This bill will not bring the improved community health care we all desire but will restrict the innovativeness and stifle the enthusiasm of your physicians.

All of you, being worldly and knowledgeable community representatives and being interested in health, know about the concept of immunity. In recent years, it has become one of the best-known topics in medicine. As you all know, immunity is our body's own ability to fight disease. Certain organs and cells in our bodies have the ability to fight off various harmful substances. If our immunity is low for whatever reason, then we become more susceptible to illness or disease. One of the most famous examples of that is AIDS, where a virus so destroys immunity that a person with AIDS has a much higher chance of becoming infected and dying.

In that interface where the world of medicine comes into contact with the political pressures of a society, we have long recognized a virus that is as debilitating and as ultimately destructive as the AIDS virus is for individual patients. That virus is the virus of government-controlled or government-directed socialized medicine. It has been tried and tested in many different countries, and on each and every occasion has led to deterioration in the quality of medical care and public dissatisfaction with the provision of medical services.

May I recommend for your reading a very clear statement about the deterioration of health care in the socialist systems. It appeared in the 19 February 1989 issue of Commentary magazine on pages 33 to 35 in the article Life under Communism Today by the respected writer Arch Puddington. The author demonstrates how every tenet of a government-controlled system's claim that it will improve health care eventually becomes one of the foundation stones for mediocrity, lack of accessibility and the diversion of precious resources away from the sick, and especially the elderly.

Here in Ontario there appears to have arisen the myth that Ontario has immunity, an immunity that no other jurisdiction on this planet has; that somehow or other Ontario will be immune to the deteriorating and destructive



effects of this virus in a way that has not happened in any other country. Why on earth do people have this fantasy that what happened elsewhere will not happen here? What on earth makes you think and believe that government-controlled medicine, of which this bill is but the latest and worst example, will work here when it has never worked anywhere else? Make no mistake about it: This bill is a bill to further advance the socialization and government control of medical care in this province.

We, as physicians, agree with the Minister of Health that medical decisions should be left to medical professionals, but right at the beginning of this bill sections 3 and 4 make it clear that the granting of a licence will be decided by a government employee, and section 5 establishes beyond the slightest doubt that the existence of these medical facilities will be entirely dependent on and at the whim of the political process.

This is the politicization of medicine and medical care. Instead of physicians establishing new facilities where they believe they can offer a new or improved technique to fill a public need, a government bureaucrat will be able to decide that for political reasons such a facility should not be established in place A where the doctors want to establish it but in place B where there may be no adequate facilities and staff and no real public need; but because member of Parliament C is in danger of losing his or her seat and needs to show the constituents that something has been done in the riding.

Physicians already have to be adequately trained and qualified to receive licences to practice, but those assessments up until now have always been carried out by appropriate academic and professional experts. This bill will change that and make licensing a political act, subject eventually to all the corruptions our daily newspapers inform us are inherent in the political patronage system.

If the government truly believes it can do a better job of setting up clinics and facilities, then we say: "By all means try, but please not at the cost of stifling the understanding, experience and initiative of the physicians who know better. Compete, don't restrict." Frankly, we do not believe you can compete. Frankly, we believe that when governments get into this sort of area they establish the wrong facility at the wrong time in the wrong place.

We believe that when the process comes under total government control, proposals become studied to death. They become delayed because of cost and budgetary considerations; they become cancelled because of political debts or arguments. Section 9 spells this out for you word for word. The minister may decide, virtually arbitrarily, that the minister does not approve of the services to be provided, perhaps abortion, perhaps eventually psychotherapy—whatever personal bias, prejudice or other allegiance any minister might have. Further, the minister can claim that money is not available or that in the minister's opinion there is no need for the services.

We believe differently. We believe that fully licensed and qualified physicians who have new ideas or techniques should be able to offer them to the public. If the public does not make use of those services, those physicians will soon have to find something else to do. If the physicians do something medically they are not supposed to do, we have very effective, some physicians would even say oppressive, disciplinary measures that can be brought against them by the public and by their medical peers. We do not need bureaucrats getting into this very vexatious area.



As the Ontario Medical Association has been pointing out, there are many aspects of this bill that have aroused enormous concern among physicians and the public. The grossly intrusive aspects into patient confidentiality, the confidentiality each of you hopes you possess when you talk to your doctor, is one of the provisions of this bill they are drawing attention to. We believe their presentation to be very clear and well thought out, and we would recommend that you take very careful note of their comments.

The citizens of this province are getting fed up with this squabbling between the government and health care workers. Let us remind you that we did not start the squabbling. We did not bring in bills to change a system that was very widely admired, that might have needed a little fine-tuning but not nuclear destruction to rectify some of the isolated deficiencies that occur in any system.

I, however, have chosen to take a broader overview for our rejection of this bill. If you ask us what we have to offer to increase community health services, we suggest to you that you encourage physicians to offer new or improved facilities and techniques by creating a climate of freedom and opportunity and not a climate of restriction and cost-cutting. If you ask us if we see any role for government in contemporary health care, we say, "Yes, most definitely." The government has an important role to play in filling in the gaps that cannot be completely covered in private systems.

Certain basic services and facilities for the poor, the elderly and the physically impaired usually require community support. Certain emergency services, blood banks and a whole variety of other needs dictate the necessity of a publicly funded support system for those unable to provide adequately for themselves or for certain situations that become a universal communal need. But the opposite extreme, of shutting out individual and private enterprise completely, is a prescription for disaster. We oppose it and therefore we oppose this bill. If it really matters to you what health care will be like in this province in 25 years' time, then please drop this bill.

1600

The marvellous Newsweek columnist Meg Greenfield, whom no one can accuse of being a rabid right-winger, recently discussed what so much of the western civilized world has come to realize as being the problems and disappointments of liberalism. She pointed out that among the most fundamental of these problems were great difficulty recognizing the difference between effectively using governmental intervention to do good things and indulging that instinct mindlessly to the point of heavy-handed coercion in the name of causes whose original objective has long since been forgotten or superseded and, similarly, difficulty in stopping short of harshly and unjustly penalizing one group by way of trying to help another that is in trouble.

She went on to say: "It all looks simple, as if no one could possibly choose the wrong alternative. But the fact is that there are a lot of people who call themselves liberals who are on the senseless side of each of these propositions."

I have just returned from a brief visit to Britain where the health care system is in turmoil. You have undoubtedly heard it said many times that in the last three years we seem to have been importing the worst aspects of the British system. It took the British 30 years to develop worthwhile private alternatives to their decayed system. My colleagues, especially those in my age group, do not want to wait that long. Neither do we look forward with any

enthusiasm to practising in our remaining years in a deteriorating system crippled by increasing rationing, limitations and restrictions.

But I must tell you that at least in Britain the government first came out with a white paper setting out in detail its future proposals for the health care system. Then last week the House of Commons social services committee published a full critique of the government's plans. Now the debate is in the public arena.

That has not been the case here. This government has not published such a white paper and let it be debated in public before any bills are passed. Instead, we have this piecemeal approach of introducing legislation in the form of bills. I do not think the democratic process has been served well by this approach. I do not think one small advertisement in the newspapers is public debate.

We do not want our health care system to slide gracelessly into mediocrity, but that is what happens with underfunded, government-controlled systems staffed by dissatisfied and disgruntled health care workers. Everyone surely knows that the best care is given by people who, from their own happiness and contentment, can open their hearts warmly and generously to give of themselves to their fellow human beings.

Please do not continue turning off nurses, doctors and other health care workers. Please start listening to the health care workers in this province.

We know the government has a huge majority. Please do not use that majority to pass this bill. Use your sense and withdraw the bill.

The Chairman: Thank you for your presentation. I would also like to congratulate you on timing your presentation to exactly the 15 minutes you were allocated.

Dr J. Berger: That is what I was asked.

The Chairman: We really do not have time for questions, then.

Mr Philip: I think he has convinced me to support the bill.

The Chairman: You are supporting the bill? Dr Berger, you have accomplished something. Thank you very much for coming.

Mrs Cunningham: I do not think that is the feeling we want to leave Dr Berger with at all. He has made a rather intelligent presentation and there are parts of it we should be taking very seriously.

The Chairman: I am sure we will do that through clause-by-clause.

The committee is adjourned until tomorrow morning at 10.

The committee adjourned at 1605.



CARON  
XC12  
-578

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

INDEPENDENT HEALTH FACILITIES ACT, 1989

THURSDAY 17 AUGUST 1989

Morning Sitting





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Epp, Herbert A. (Waterloo North L) for Mr Daigeler

Hosek, Chaviva (Oakwood L) for Mr Beer

Matrondola, Gino (Willowdale L) for Mrs O'Neill

Philip, Ed (Etobicoke-Rexdale NDP) for Mr R. F. Johnston

Reville, David (Riverdale NDP) for Mr Allen

Smith, E. Joan (London South L) for Ms Poole

Clerk: Decker, Todd

Staff:

Luski, Lorraine, Research Officer, Legislative Research Service

Witnesses:

From the Sault Ste Marie and District Group Health Association:

Ross, Helen, Director of Planning, Research and Development

Individual Presentation:

Brannan, Gina

From the Ministry of Health:

Sharpe, Gilbert, Director, Legal Services Branch

Caplan, Hon Elinor, Minister of Health (Oriole L)

MacMillan, Dr Robert, Executive Director, Health Insurance Division

From the College of Optometrists of Ontario:

Lamont, Donald H. L., Legal Counsel; with Lamont and Lamont

Baker, Dr Irving, Registrar

From the Royal College of Dental Surgeons of Ontario:

Dunn, Dr Wesley J., President

Ellis, Dr Roger L., Deputy Registrar and Registrar-Elect

From the Ontario Psychological Association:

Nielson, Dr Warren, Chair, Legislation Committee

Berman, Dr Ruth, Executive Director

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 17 August 1989

The committee met at 1008 in room 151.

INDEPENDENT HEALTH FACILITIES ACT  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: I will call the meeting to order. This is a meeting of the standing committee on social development and we are convened to consider Bill 147, An Act respecting Independent Health Facilities. We have been holding hearings for several days now, welcoming groups and individuals from across Ontario which have been commenting and giving advice with respect to this piece of legislation.

Today, we have probably the fullest agenda we have had and some significant province-wide organizations coming, so I am going to try to keep pretty close to the mark in terms of our timing so that we do not short-change some of these province-wide organizations that will be before us today.

SAULT STE MARIE AND DISTRICT GROUP HEALTH ASSOCIATION

The Chairman: Our first group is the Sault Ste Marie and District Group Health Association. Helen Ross, director of planning, research and development, will make the presentation. Welcome to the committee. Would you take a chair across from here? We have allotted you 15 minutes. Hopefully, there will be some of that time for questions, but we are interested in hearing what you have to say.

Mrs Ross: I will speak quickly.

Mr Carrothers: Not too quickly, though.

Mrs Ross: The Sault Ste Marie and District Group Health Association has been providing and/or arranging health services to the people of Sault Ste Marie and district for over 25 years. It is governed by a voluntary, community-based board of directors representative of the patients served. Today, the centre provides health care to any member in the community, but ties to the local steelworkers through board representation and third- and fourth-generation enrolment are still prevalent. The steelworkers were our original sponsors and they provided the capital for the building and equipment through voluntary contributions.

The association has operated on the capitation model throughout the years and has emerged as the largest health service organization in Ontario. Our roster of voluntary enrolled patients consists of over 40,000 individuals from the city of Sault Ste Marie and the neighbouring service area. Although the vast majority of its patients are from the enrolled population, the centre also serves a number of fee-for-service patients, particularly in such areas as oncology and nephrology, where the only local specialists are members of the associated medical group. The combination of rostered population and fee

patients represents approximately one half of the district of Algoma's total service population of 100,000.

The association has a contract with the Algoma District Medical Group which provides or arranges for medical service. The not-for-profit association and the independent partnerships of physicians function together, according to the terms of an agreement, as the Group Health Centre. At present, the medical group consists of 42 physicians who provide general and specialty medicine to our patients. The physician services are complemented by a wide variety of services available from allied health care professionals. Over the years, the centre has developed alternative practice patterns by providing a multidisciplinary team approach to health care.

When the Minister of Health, the Honourable Mrs Caplan, appeared before this committee on 8 August, she explained the intent of Bill 147 as follows:

"The Ministry of Health is spearheading a move to provide a setting to promote and foster the growth of more community-based health services that can be safely provided outside the hospital setting. The Independent Health Facilities Act...will be the government's major instrument to allow for this profound positive shift in direction that is planned for health care in Ontario. It is a major part of the government's commitment to improve...health care in Ontario.

"For example, funding incentives under the act will be used to expand community-based health care in our northern communities, often experiencing remoteness and challenges of geography. It will allow for program and service expansion of our popular community health centres and health service organizations."

As a resident of northern Ontario and a representative of Ontario's largest health service organization, I commend the Minister of Health on this new legislative initiative. The absence of a flexible funding mechanism for community-based services has restricted the scope of services offered at the centre although the HSO alternative funding mechanism has provided considerable program growth.

Over the years the centre has endeavoured to provide community-based programs which would facilitate optimal health outcomes for the residents within our service. Such programs as the back care program, the pain clinic and the various programs from the women's health centre, although only a small sample of the programs we offer, all have a focus of health maintenance, illness prevention and the promotion of optimal functioning.

Another thrust in community-based programs has been and continues to be the provision of day surgery. Day surgery is recognized as being a cost-efficient alternative to inpatient surgical procedures and has been integrated in Canadian hospitals. However, free-standing day surgery facilities are virtually nonexistent in this country. Therefore, the only comparative data we have found was in the United States where such facilities are much more common.

Experience in the United States has shown there are advantages to free-standing day surgery clinics. Free-standing day surgery has been shown to be less expensive than either inpatient surgery or outpatient surgery affiliated with hospitals. The study done by the Orkand Corp, published in 1986 for the Department of Health, Education and Welfare, found that free-standing surgery charges were 55.3 per cent less than inpatient charges

and 11 per cent less than hospital outpatient charges for identical procedures. The Orkand study also found that the vast majority of physicians were very satisfied with free-standing facilities and patients indicated that they preferred the free-standing centre and would return there for similar procedures.

An important factor that must be addressed in discussing day surgery is quality of care. The Orkand study found no major differences between quality of care received in either hospital or free-standing setting. The study found that 0.3 per cent of patients treated at a free-standing centre required transfer to hospital care. All transfers resulted from the detection of malignancy, requiring additional surgery. These transfers were not related to the level of care nor the quality of care received at the free-standing centre.

Recent contacts with free-standing day surgery centres in North Carolina showed a transfer rate of less than 0.2 per cent and a very high rate of patient and physician satisfaction.

While there is a definite financial advantage to implementing free-standing day surgery facilities, there are other equally important reasons. Health service organizations were developed in the province with the philosophy of providing care using innovative methods. One of the aims of the group health centre was to provide appropriate ambulatory care as an alternative to care in a hospital setting. In providing such care, independence and maintenance of optimum function for patients was fostered.

From its early years, the Group Health Centre has provided limited day surgery to its patients. However, since there was no mechanism either under capitation, fee for service or ambulatory care incentive plans to pay the costs of running a day facility, we as a not-for-profit corporation were not able to expand our programs to the extensive list of procedures, as we would have liked.

Our present funding mechanism provides for the physician component of ambulatory day surgery but does not recognize the facility cost of equipment and operations which are normally provided through the institutional sector. Therefore, we welcome Bill 147 and look forward to being grandfathered into the new program.

Three years ago, we completed an extensive feasibility study for expansion of day surgery at the Group Health Centre. At that time, day surgery services provided at the local hospitals were subject to scheduling delays of six to eight weeks for nonurgent cases and two to three weeks for urgent cases. This had resulted in some urgent cases being admitted and scheduled for expensive inpatient surgery.

After the investment of considerable time and resources, the Group Health Centre recognized we could not proceed with an expanded program. We continued with providing day surgery which did not require general anaesthesia, diagnostic procedures such as colonoscopies and gastroscopies, services for daily dressing changes and wound care to ambulatory patients and popular pre-operative teaching programs.

Until this time, there has been no mechanism available for not-for-profit corporations to obtain the necessary operating and capital funds for a comprehensive day surgery unit. This situation restricts the Group Health Centre in a way that prohibits it from developing its optimal potential in keeping with the philosophy of a health service organization.



We see community-based programs such as these day surgery units as an attractive alternative to inpatient hospital care, and in keeping with the ministry's desire to foster safe community health services provided outside of traditional institutions. Bill 147 could represent a new phase in the development of community-based services. We welcome the removal of historic barriers to the expansion of health service organizations and look forward to working with senior ministry staff in the grandfathering process once this act is proclaimed.

1020

On behalf of the Sault Ste Marie and District Group Health Association, I would like to thank Mrs Caplan, the Minister of Health, Dr Robert MacMillan and Gilbert Sharpe for this innovative initiative within the Ontario health care system.

The Chairman: Thank you for your presentation. It has been most interesting. I think many members of our committee have followed with interest the work of your organization.

We have about six or seven minutes left, and I will try to spread it around as fairly as I can.

Mr Carrothers: I will try to take just two minutes, Mr Chairman. Like the chairman, I have followed what your group has done and have been very impressed with the things you have been able to accomplish and I appreciate your coming in to share your views with us.

Have you had an opportunity to look at the sections in Bill 147 that deal with what has come to be called quality control? This has been the subject of a fair amount of discussion before this committee. Since you have nodded, I guess you have. I am wondering if the types of things this bill sets out as inspection procedures and so on cause you any difficulty or if you think that essentially those are what are needed or whether you have any problems with how that quality control process would work?

Mrs Ross: I think quality control is absolutely essential. We have a quality control program, even though we are not committed to it by any legislation. We have had quality control in our programs and we have a formal program at the centre. We would certainly expect that there would be quality control in the additional services we provide.

Mr Carrothers: So you are not seeing any difficulty in the provisions in this bill in that regard?

Mrs Ross: Not as I remember. I do not have a copy in front of me, but certainly quality control would not be—

Mr Carrothers: Nothing struck you when you went through it. Thank you.

Mr Philip: Thank you for an interesting brief. Are there any particular programs running out of your facility that are not directly supervised by a medical practitioner but rather under the sole direction of other professionals, other than people with an MD after their name?

Mrs Ross: Yes. The Women's Health Centre is basically a nurse practitioner directed service. Of course, we have medical backup to all of our

programs. We have a physio department, we have chiropody, we have communication disorders. I am trying not to forget anyone; it is more than my life is worth. We have a number of programs that are not physician-run, but each has a connection with the medical component. Dietary is the other one.

Mr Philip: And these are funded how?

Mrs Ross: They are funded through the capitation process. They are programs have managed to develop because of the alternate funding.

Mr Philip: Are there any programs you foresee a need for that you could do after this bill is passed that you cannot do under the present system?

Mrs Ross: The day surgery unit is one of our major concerns we would like to do.

Mr Philip: That would be your major emphasis?

Mrs Ross: Yes. We are looking at, not directly related to this, extramural hospital; it certainly may have some impact on the Women's Health Centre we are already functioning.

Mr Philip: I have a number of other questions, but I do not want to be unfair, Mr Chairman.

Mrs Cunningham: Thank you for a most interesting brief. You are well known to this committee and your services are referred to frequently. You mentioned that the capital was a real problem for you and that this bill will now allow you to go to the government and get some capital funding. We are looking at nonprofit groups starting up. Were there ways you considered to raise capital on your own? Did you ever consider looking at a large fund-raising operation to raise money for your own capital at one time, and how successful were you?

Mrs Ross: Initially, we were very successful in raising the capital for the building and the equipment. At that point each family paid \$135; that was before medicare, of course. I guess that would translate to about \$1,000 nowadays. There was the commitment there with the original group. We have not done a lot of major fund-raising since. Of course, it comes up on various projects that people are looking at fund-raising, and the hospitals are now looking at it. No doubt, we will be in that position at some point also. But we have not done anything major for raising funds other than the original one to get the building and the equipment.

Mrs Cunningham: How did you pay for the building and equipment, by charging a fee of the people coming in?

Mrs Ross: No. The original building and equipment was paid for by the original sponsors. They paid \$135 a family. That was almost 26 years ago, to put up the original building and equipment.

Mrs Cunningham: You must have had an awful lot of families involved.

Mrs Ross: I cannot give you an exact number but I think it was around 3,000 to 5,000. I can get you that number if you are interested.

Mrs Cunningham: No. I just think 3,000 to 5,000 sounds wonderful.

Mrs. Ross: We really do owe a lot to our original sponsors. The steelworkers were very dedicated to medical services.

Mrs. Cunningham: That is how the money was raised, I gather to support, in this case, a group of people who put it together—a very large group. That is an exciting model. In today's world, you would say though that we would have to raise the money otherwise—with capital dollars through this bill, with the ministry putting the money up.

Mrs. Ross: I would guess it would be very difficult to repeat that 26 years later.

The Chairman: Because of the interest in this, I think we have time for one more quick round of a quick question from each party. Ms Hosek and Mr Philip indicated they had some more questions.

Ms Hosek: I was just going to add my sense of wonder and pleasure at the wonderful work you have done for so long and the model you offer for health care in Ontario. I am simply struck by the fact that you are serving 40,000 people with 42 physicians. I think that is absolutely astonishing.

Do you find that you suffer from a shortage of physicians or is the way you deliver service, with the involvement of all the other health professions, one of the reasons you can do this?

Mrs. Ross: I think the multidisciplinary group approach certainly is one of the major ways that we can do that. Like everyone else in the north, occasionally we suffer from lack of being able to recruit physicians to come to the north, but with a full complement of physicians we use nurse practitioners. We use other professionals in primary care and we seem to be able to more than adequately provide for our patients. We have very loyal patients.

Mr. Philip: I will pass.

Mrs. Cunningham: I always have one more quick question.

Mr. Carrothers: Dangerous question to ask her.

Mrs. Cunningham: I am wondering if you worked, at that time or now, through your district health council or with them.

Mrs. Ross: We work through the district health council and with them on just about anything that happens now. I do not believe there were district health councils, as we know them now, 25 years ago.

Mrs. Cunningham: That is right.

Mrs. Ross: It was a community initiative and I think that one of the things that has made our organization successful is very much that we still have contact with these original people and their families and they feel they very much own this. Our board feels it very much has the say about what happens.

Mrs. Cunningham: Are you represented in any way on the district health council? Do you have members of your own group who are on the district health council?

Mrs. Ross: Not at this point.

Mrs. Cunningham: Another quick one?

The Chairman: I think to be fair to the others who have a restraint.

Mrs. Cunningham: If they have quick ones, that is fine.

The Chairman: Thank you very much for coming before us with a most interesting presentation.

Our next presentation is by Gina Brannan. Welcome to the committee. You have 15 minutes, which should include your presentation and, hopefully, some time for questions from the committee members.

GINA BRANNAN

Mrs. Brannan: I would like to thank you for the opportunity to come before you today as a private citizen and a consumer of our health care product, which clearly becomes more and more expensive as each day progresses.

I am a former policy adviser to a provincial Minister of Health and someone who is clearly familiar with the political process and the political realities of formulating policies that will be successful with respect to any party which wishes to form the government.

However, I appear before you today in a more important capacity, as a consumer of our health care product, a consumer who is concerned that the legislation that is presently before you, although formulated with the consumer in mind, will in the end provide the vehicle by which the delivery of health care can be controlled by government with a view to saving money.

1030

I would like to make it perfectly clear that I do appear before you as a private citizen and notwithstanding my professional career, I represent no one but myself.

I intend in the short period of time that I have before you today to concentrate on how this bill affects the funding of the delivery of health care to the consumer. I recognize that there is a large issue in respect of the confidentiality of patient records, mine and yours. However, I will leave this issue to others, in particular, the privacy commissioner who I understand either has or will be appearing before this committee.

The main philosophy behind this bill clearly must be lauded, to move services that are presently being performed in our hospital setting to the community, thereby reducing the costs of health care and at the same time increasing the ability to deliver more services to all parts of our province. The philosophy is sound. There is no question about that. However, as we move to a closer review of Bill 147, my concern heightens with respect to whether you will in fact be able to deliver that service.

I refer you to subsection 3(3) and section 23 of the bill. I ask you to continue reviewing these as this committee meets and after when you go into your caucuses. Combination of these two sections of the bill produces a situation where no facility fee can be charged to a patient in relation to an



insured service and further allows the government of the day to decide the method of payment for the services delivered in the independent health care facilities.

I fear global funding of community health care clinics. I fear global funding of our abortion clinics and I fear global funding of our reproductive clinics.

In other words, the government of the day can fund these independent health care facilities in the same manner in which hospitals are funded, through a global budget, and we all know how successful the funding of health care in our hospitals has been through global budgets. We cannot keep up with the high technology.

We only need to go to the case of Mr Coleman, who died while he was on a waiting list for heart surgery, to see how our global budgets have worked.

It may be considered laudable by many that the government wishes to deliver health care to the people of this province for free. I am the first one to say that I do not want to see a return to a situation that we had before. But it becomes ludicrous to say health care is free in Ontario when it cannot be delivered with any regularity.

It is free but we cannot deliver the product because there is not enough money to do so. It is like the loss leader in the local hardware store where you can get your free bag of fertilizer and you go in and the fertilizer is not there. That is misleading advertising and the Competition Act that we have presently in the federal government poses large penalties for people who mislead.

That brings me to a situation upon which I can speak with some authority and that is reproductive clinics, the clinics that offer couples who cannot conceive the opportunity to have children. My husband and I were just such a couple. We were told that we would never ever have the opportunity to have a family. Without the reproductive clinic at LuCliff Place and the dedication of the doctors and their clinical staff who work seven days a week, starting at 6:30 am, I would not appear before you today with only three weeks to go before I deliver our first child.

When extra billing was banned, one of the first things to be affected in our hospitals, due to funding through global budgets, were the in vitro fertilization clinics. Doctors involved in reproductive work had to develop a methodology that could be carried out outside the hospital setting, an alternative to in vitro fertilization.

This resulted in what is known as the sperm wash program, and I am sure Dr MacMillan can explain that a lot better than I can. The success of the sperm wash program, I might add, has been better than in vitro fertilization. It is clearly less expensive and is less intrusive.

Presently, doctors and clinical staff who operate reproductive clinics are able to take on as many women and couples as they can physically handle because they are not restrained by a global budget. Men and women who are involved in this program pay for the drugs and the procedures required in order to conceive that are not covered by our Ontario health insurance plan.

The drugs alone can run as high as \$1,000 per cycle and the incidentals can run approximately \$200 per cycle. That is per each time that you give it a try.

In the program that my husband and I were involved in, there were approximately 29 other couples. Simple arithmetic tells you that the extra costs for 30 couples in one clinic for one cycle were approximately \$36,000. This government cannot afford, no government can afford, to fund that. If you spread it over 30 couples though, it becomes a lot easier to bear. You also have to understand too that with our extended health care programs, a lot of those extra costs are picked up, and in the end I believe my husband and I paid approximately \$400 to conceive a child, when we were told we would never be able to do so. In the United States, the same program would have cost my husband and I US\$15,000.

Multiply the \$36,000 over a 12-month period by the number of reproductive clinics in the province and it becomes abundantly clear that the government of Ontario will not be able to afford these clinics and the number of couples who will be able to access these clinics will be reduced. I am not prepared to stand by and have the government determine whether or not I will have a second child for the sake of political expedience, because they want to be able to state that health care in the province of Ontario is free. Free will become, as it has in our hospitals, synonymous with being unable to deliver the product. It will be free, but not accessible.

If this bill is passed in its present form and disallows fees that are related to insured services, which the drugs would be, and at the same time allows the Minister of Health or the government of the day to fund independent health care clinics on a global basis, and I see no prevention of that in this bill, doctors and clinical staff operating these clinics will only be able to deliver the service to a handful of couples during the course of a year.

I understand and respect that some clinics, for example clinics such as the Morgentaler clinic, where there is a facility fee of approximately \$200, or it would be called a facility fee once this legislation is passed, that the government intends to grandfather some of these clinics. I would like to see the reproductive clinics grandfathered too, but I am not sure this is the whole answer for either the abortion clinics or the reproductive clinics. Witness the grandfathering of private physiotherapy clinics; that has not worked. It has not worked at all.

In the original bill, if I am correct, and I am sure Dr MacMillan can correct me, subsection 3(3) had at the end of it, after the words "under this act," "except as provided in the regulations." It is the out. It is the wording that will permit the government to address situations as they arise, just as this reproductive clinic may arise, and all of a sudden you realize there is no way we can afford to service all these people.

The reproductive clinics are only one example. Think of the services that can be delivered to our ageing baby boom population through community clinics. One that comes immediately to mind is eye clinics. The government will not be able to afford to deliver, completely free of charge, the services that will be required for this bulging part of our population.

The government cannot afford to be reactive. Health care is much too important. The bureaucratic process is much too slow to be reactive. Government must be proactive. It must think ahead and it must provide avenues for itself in the event that it does not think of every single eventuality, every situation that this bill may affect in the delivery of health care in this province.

Leave that opening for yourselves, please. Please leave that opening

that will permit government to respond to situations as they develop or are discovered. Do not pass a bill that you believe to be politically expedient, so that you can say health care is free. It is not free. We have to pay for it through our tax dollars. Do not destroy a bill that has a sound philosophy, community health care, but does not provide the financial mechanism or the way of changing the financial mechanism to deliver it. You have to be able to deliver the product.

My husband and I would like to have a second child. Please do not take away that opportunity, please do not make me go to the United States and please do not make me have to pay US\$15,000 to have my second child.

The Chairman: Thank you for your presentation; an interesting perspective. I think we have time for a couple of quick questions.

1040

Mrs E. J. Smith: I did find this a very interesting presentation which really goes to the root of Bill 94, possibly more so than this bill, and what are considered the essential health care services, which in Bill 94 we have addressed.

Allow me to be theoretical and not present a philosophy of this government at all. I would think of the two examples you have given, eye surgery or eye care would automatically be part of health care to anyone. Therefore, if it is not being delivered as well as it might be because of numbers and so on, would you not see this as the way to improve the delivery and make it more accessible? This particular bill acts as a partner to Bill 94 and is trying to improve the delivery of service.

Mrs Brannan: It is clear that the bill acts as a partner to Bill 94, to cover or to respond to those loopholes where, in some situations, you go in and there is an administrative fee charged. There is no question about that.

There is no question that this piece of legislation will assist in delivering our health care product at the community base, of which I have always been a big proponent, because I believe you get better, more personal care that way. The problem I foresee with some of the high-technology medicine, which can be delivered at the community health care level—and reproductive clinics are probably the most perfect example—the costs are so high that you have to leave yourself an out in this legislation that will permit a facility fee to be charged where necessary. In this case, you have drugs costing \$1,000 per cycle.

Mrs E. J. Smith: I understand that. You made that point. I just wanted to say that seen as a partner of Bill 94—I can remember at the time that it was introduced, Bob Nixon saying to some of us what it cost per child to be cured of leukaemia.

Mrs Brannan: A fair—

Mrs E. J. Smith: He said, "This is a philosophical, political decision that has to be made by the people in those positions." I see this as a philosophical political decision too. Speaking only for myself, I would certainly see anything like eye care as essential to the delivery of service, and this is an improved way.

If philosophically, we regarded fertilization clinics as a luxury, which



is what you are suggesting we should be doing, and not an essential service, then does this bill not allow for that? It would simply be an uninsured service like facial corrections, plastic surgery.

Mrs Brannan: As I understand the legislation, if there is any type of administrative fee charged—

Mrs E. J. Smith: For an insured service.

Mrs Brannan: No, for anything even attached to an insured service.

Mrs E. J. Smith: We can get some clarification later on that.

Mrs Brannan: You can get some clarification from your legal counsel. My understanding is that attached part which you are paying for out of your pocket immediately puts the clinic in a situation of breaching the legislation.

Mrs E. J. Smith: We will get some clarification on that after, because I think it is an important point.

Mrs Brannan: All I am asking the committee, particularly the Liberal members of the committee, because you have the control of the House to make the decisions, I am merely asking you to consider leaving yourselves an opportunity to respond to situations that you may not be aware of right now.

Mr Owen: Mr Chairman, could we have that answer, because I think it goes to what you are saying?

The Chairman: I was waiting for the deputant to conclude her remarks. Could we have a clarification of that?

Mr Sharpe: The bill, both within the regulation-making power of this bill and the proposed amendments to the Health Insurance Act, where we are suggesting that the constituent elements of an insured service could be specified, provides for the option that the kinds of adjunctive fee services that you pay for out of your own pocket, if the desire were there, they could be declared either an integral part of the insured service, an expanded fee in other words under OHIP, so that the physician could be compensated for it, or both under the Health Insurance Act and under this bill, could be declared an uninsured service. So it would not be an insured service for the purpose of the Health Insurance Act and it would not be a facility fee for the purpose of this act. As an uninsured service, it could then continue to be direct-billed to patients.

Bob, I do not know if you want to comment on the negotiations with the Ontario Medical Association. We are attempting to deal with a large number of services in the so-called grey zone to try to decide which category to place them in, but it is certainly possible that the sorts of services you have described might be construed as facility fees, and if that were to be the case with the proposed government amendment, they could not be direct-billed to patients.

Mrs Brannan: That is my concern and because of the high costs of reproductive clinics—I do not view them as a luxury for someone such as myself, who cannot conceive—and because government can pay out only so much, unless you have a money tree out in the front of Queen's Park, we have to be prepared to spread some of those fees among people who want that type of service. Otherwise, it is not going to be available to us. That is my concern.



Mrs Cunningham: I think the clarification should be pursued further.

Mrs Brannan: I would agree with that.

Mrs Cunningham: I wonder, if we do have some difficulty—the old subsection 3(3) says "except as provided in the regulations"—you are suggesting that would open it up a bit.

Mrs Brannan: It would open it up because then you would be able to add something to the list of things that can be prescribed by regulation that would address the situation Mr Sharpe has said in the event that these adjunct fees are considered facility fees and therefore not committed to be charged directly to the patient.

I do not have to tell the legislators sitting around here that it is so much easier to do it by regulation than by having to amend a piece of legislation. The words "except as provided in the regulations" provide a great deal of leeway. You either use it or you do not use it. There is nothing mandatory about having to use it unless a situation presents itself where you should.

The Chairman: You presented an interesting perspective and we thank you for it.

Our next delegation is the College of Optometrists of Ontario. Representing that organization are Dr Irving Baker, registrar, and Donald Lamont, legal counsel. Welcome to the committee. We have allotted you a half-hour and committee members would appreciate if some of that time could be left for questions.

#### COLLEGE OF OPTOMETRISTS OF ONTARIO

Dr Baker: As a matter of fact, we will try to speed it up and make it shorter. My sense is that we are likely to be the first governing body that has appeared before you. I may be wrong, but that is my sense of it. Therefore, I think we are going to pursue a direction somewhat different from anything I had the opportunity to listen to this morning.

With this in mind, I suggest to the committee that at the very outset in this presentation I would like to make it clear that the college's interest in Bill 147 is that of a governing body of a profession that is explicitly included in the legislation. Our approach to considering the bill has been primarily to limit our consideration to those provisions that bear directly upon the administration of the bill, as it may affect the colleges or our college and as it pertains to our practitioners and the protection of the public. I believe this was reflected in our one-page submission to you dated 8 August of this year.

We became aware on 15 August that there was a government motion tabled with respect to section 1. While I have it in my presentation, I will not repeat it, but you are aware of what we are talking about in terms of amending the definition of "registrar." We have considered this motion and agree that it reflects and addresses the concern we stated in our initial submission; that is, the bill, which in fact is an enabling piece of legislation, should provide the proper referral procedures so that the appropriate governing body may take appropriate action in dealing with its own members. However, in our view, the single amendment by itself—we have concluded this—does not clarify in statutory terms the process to be followed.

1050

To clarify the basis of our conclusion, as well as perhaps to assist in the considerations of the committee, we would offer the following amendments to the bill. I will read those, but I do have copies which I will leave with the clerk at the end of the presentation. We offer the following amendments:

Under subsection 1(1), we suggest that the definition of "college" be amended to read, "'college' means the governing, registering or licensing body of a health profession."

Second, under subsection 1(1), we recommend that the definition of "physician" be amended to read, "'physician' means a legally qualified medical practitioner entitled to practise medicine in the place where medical services are rendered by him or her."

Third, we offer the suggestion that you add, "'practitioner' means a person other than a physician who is lawfully entitled to render insured services in the place where they are rendered."

Those definitions, I should point out, were not dreamt up by us. They are simply out of the Health Insurance Act and we felt there should be some consistency in the definitions.

Under subsection 24d(3), we suggest that under clause (a) should be added a clause (aa) which would read "must be a practitioner from the same profession as the services as provided by the practitioner in the health facility." All we are really saying is that you have the same assessor in the same profession assessing the person who is to be assessed in that particular practice area.

We also offer the suggestion that under subsection 24e(1) the word "medical" be deleted and replaced by the word "health" in line 3 and that under clause (a) the word "medical" simply be deleted before the word "records" in line 1.

In making these or any similar amendments that the committee sees fit to make to the bill, we believe that much of the ambiguity we feel is currently present would be minimized or eliminated. Those are the things we would offer, from our perspective, in terms of setting up an appropriate governing body mechanism to deal with its own practitioners.

The college should point out to the committee that we have reservations concerning section 33; that is, the power of the Lieutenant Governor in Council to make regulations. We have this reservation in general because the items that are listed in this section are so very general and so very open to interpretation that it is difficult to conceive what in fact will appear under those particular powers to make regulations. In order to make our point perhaps a little bit more meaningful, I would like to point out a couple of items that could turn out to be in conflict with the Health Disciplines Act.

If we look at paragraph 33(1)8, which says, "prescribing and governing the quality and the standards of services provided in independent health facilities or any class thereof," may I interject and state that we have great difficulty understanding the last four words. I have asked Mr Lamont to explain "of any class thereof" and he has had difficulty with that. We are not quite sure what that means. But looking at paragraph 8 and then turning to clause 94(f) of the Health Disciplines Act, under that act the college has the power to make regulations "governing standards of practice for the profession."

Again, if we look at paragraph 33(1)14 of Bill 147, under the power to make regulations it states, "prescribing and governing the records that shall be kept by licensees with respect to the care and treatment of patients of an independent health facility," and then turn to the Health Disciplines Act and look at clause 94(s), we find there is also the power for the college to prescribe "the records that shall be kept respecting patients."

If there is a conflict or difference between the two in the regulations between the two statutes, the obvious question that arises is, which one would prevail?

To put it another way, when an assessor goes into a health facility and is making an assessment, is he guided by the regulations one finds under Bill 147 or is he guided by the regulations and the publications that are in the Health Disciplines Act and the publications of the particular college? In other words, what are his criteria for making the assessment of that particular practitioner, not the facility per se but the actual services being performed or the actual records being kept?

Last, we would like to make a comment and raise a question. If one looks at paragraph 33(1)17, under the power to make regulations, which states, "governing access to patient or drug records and specifying persons who may have access to such records," in our view it appears to anticipate that others than governing bodies of the professions will or may have access to the records of patients. Because we do not know exactly what the government has in mind, the college would simply ask if this is really necessary and would it be in the best interests of patients who require and use health services?

That concludes our remarks and we would be pleased to entertain your questions.

The Chairman: Thank you very much for the presentation and for leaving some time for questions. We do have some, beginning with Mr Carrothers.

Mr Carrothers: I appreciate you coming forward with those suggestions. Since you have put the issue of inspection on the table, I am wondering if I might ask a bit about what your college does in terms of what is often called peer review or reviewing ongoing practitioners.

Dr Baker: Yes.

Mr Carrothers: Do you have a program and what sort of activity does your college undertake in that light?

Dr Baker: We have two. We have one under the Ontario Health Insurance Act that acts as inspectors through our optometry review committee. We also have a system where we have assessors going into the field, based upon complaints that we might have. We also have a system under what we call an appraisal committee, which is a rather unique committee within the five colleges, other than medicine, which recently has a quality assurance committee. We have had a so-called appraisal committee since 1974, and before, which looks into the standards of practice. So we have to a large extent a proactive activity in this area.

Mr Carrothers: So that a member of your college who is regulated would be subject to a visit, perhaps out of the blue, from—

Dr Baker: Yes, but generally at this moment in time there has to be a reason.



Mr Carrothers: A complaint.

Dr Baker: Yes. There would be one other comment I should really make about this with respect to standards of practice. This was clarified in the Divisional Court with respect to an Ontario health insurance plan matter.

There was a ruling by the Health Services Appeal Board a number of years ago that overturned the decision of the general manager and the optometry review committee with respect to its recommendations, based on the technicalities of how the coverage was worded in the Health Insurance Act.

At the request of the ministry of the day, the matter was appealed. The Divisional Court ruled that the Health Services Appeal Board had erred, but it also confirmed the fact that not only do the regulations apply within the Health Disciplines Act, but also the publications of the college can be applied in having the effect of law. This is one of the things that concerns us when we look at the administration of the quality of services.

1100

There is one other comment I would like to make. I really do not want to pursue it, but I think I should put it on the table. Reading this particular statute, we found it extremely difficult to interpret it. We are not sure if we understand it yet, quite frankly. We have read the fact sheet and we have no problem with the fact sheet because it is quite apparent what it is targeted at and the reasons for it. However, when we read the statute, it appears that implicit in the statute, it goes far beyond the immediate objectives of this statute as stated in the fact sheet.

In other words, we can interpret this, and we do not know whether we are interpreting it correctly, as creating a new health delivery system of a different type as well as a new payment mechanism of a different type in the province that would be predicated on this statute.

That is a political matter and as a college we have tried to stay away from that; that is our association's business. But we do have concerns because the wording of the statute is so fluid, if you will, that it can almost be interpreted any way anybody wishes to interpret it. This is where we have had difficulty. We have stuck to our knitting and dealt with what we thought we knew.

Mr Carrothers: I am wondering, though. It is an interesting point and I guess it raises a problem you have in drafting legislation when you are moving into new areas, and that is keeping it flexible enough to deal with changing situations. I am aware of a number of statutes that have almost become useless because the circumstances under which they were drafted and the thinking at the time changed. I wonder if that is not really what you are saying.

Dr Baker: No. I agree with what you are saying, but the comment I have about it is that if it has to be jockeyed or changed, most of the significant changes are not matters that are in fact likely to be in the enabling legislation, because there is so much regulatory power built into the thing that our guess is that most of the unforeseen problems can be dealt with by regulation as opposed to going in and having an amendment to the statute.

In other words, what we see is a very broad statute that almost covers anything you want to say it covers and then you can adjust it by regulation.



That may be a good thing or a bad thing. That is simply an observation. If you are working in this field, it does raise some questions because you just do not know exactly where it is targeted.

Mr Carrothers: It is certainly a trend in legislative drafting to create statutes like that.

You mentioned you had an innovative plan with some guidelines, the quality assurance comments again, and that you had some clinical standards and guidelines.

Dr Baker: Yes.

Mr Carrothers: Is it possible to table them with the committee so that we can have them?

Dr Baker: Sure. We will be glad to table with the committee.

Mr Carrothers: We are quite interested in that.

Dr Baker: Sure. No problem. It is in print and we will make sure you get it. We will send it to Mr Decker.

The Chairman: That is fine.

Mr Carrothers: Just a final question then, because I know there are others: If there is not a complaint but you do find somehow that there are some problems with how one of your members is carrying out his practice, what happens? What do you do? Can you respond to that?

Dr Baker: Yes, we can. As I say, we have two mechanisms. I did not know how far you wanted to go into it. One was the optometry review committee method, a direct request. The other is that we have had for some 15 years now a mandatory continuing education program. If the member fails to comply with that mandatory continuing education requirement, we enter and take a look at what he is doing. It is not the best process. We are reviewing that now.

If we get a call, and we do not like anonymous calls, but if the nature of the call gives me concern that there may be something going on, we will send an inspector in and take it from there.

Mr Carrothers: Could you perceive the college—

The Chairman: I think we should move on.

Mr Carrothers: All right.

Mr Reville: Thank you for your presentation.

Dr Baker: You are welcome.

Mr Reville: I too have concerns similar to yours about the very vast clutch of the regulations section. Almost anything could happen there and I presume we will not see the regulations until some time after the bill is passed, and that is a problem. I do not really have any questions. I am wondering if Mr Sharpe would undertake to comment on the amendments you have offered, either now or later.

The Chairman: I was going to go to him after you were done your questions, but we can do that now.

Mr Reville: That is it. You can use all my time. I am feeling very generous today.

The Chairman: Good.

Dr Baker: Would you like a copy?

Mr Sharpe: No. I have taken some notes. What I will do is make some general remarks and try to respond to some of the issues you raised.

Dr Baker: I appreciate that. Thank you.

Mr Sharpe: For example, in section 33 of the regulation-making power, you have raised a couple of items, and item 14. We have given ourselves the authority to prescribe records that must be kept. You have indicated quite correctly that under the Health Disciplines Act there are similar requirements where you as the college can provide that your members keep certain kinds of records. We were very much aware of that when we put this together.

The notion of an assessor from your college assuming ultimately that optometrists obtain licences and are assessed at our request in terms of quality of care and standards and so on under this bill—His role acting under the bill would be to monitor the keeping of records as prescribed ultimately in a scheme established under the regulations for all independent health facilities. The notion that there must be proper records kept, what those should be, would be generic descriptions for the various licensed facilities to ensure that they maintain their records.

We would hope it would be done, that those regulations would be written in conjunction with the various governing bodies to make sure the provisions are consistent with one another, but the purpose for which your assessors would be going into these facilities would be to determine whether they are in compliance with the standards we have set under these regulations.

It may be that pursuant to that investigation you have concerns about your own standards of recordkeeping and your own concerns under the Health Disciplines Act being breached. That might trigger an independent investigation pursuant to your separate powers under that statute, but your inspection and assessment under this act would be for the purpose of enforcing the standards that are set in terms of recordkeeping.

As I say, it was at all times considered by the government as important that as those regulations were being drafted, the various colleges would be consulted to make sure that there is a consistent approach in the regulations that are ultimately developed.

You have mentioned in item 17 the notion of the authority to govern, records, access to records, disclosure and so on. This was put in because of concerns that there should be some scheme in the regulations dealing with recordkeeping in the sense that it is dealt with in the regulations under the Public Hospitals Act. As up until now a number of the procedures in these clinics have been done primarily in hospitals and things like day surgery now are going to move out, we need a consistent scheme for accessing records and disclosure of records and the protection of confidentiality to the kinds of things that are in the regulations under the Public Hospitals Act. That really

was all that was contemplated. That regulation-making power is similar to what exists in the Public Hospitals Act.

You mentioned when you started out concerns about expanding the definition section; for example, the definition of "college" and some other things of that sort. We have looked carefully at that, and at present we are exploring with legislative counsel the notion of whether any additional definitions may be required to the expansion of the notion of "registrar."

The only concern we had conceptually was that, for example, when the College of Physicians and Surgeons of Ontario is asked to inspect and assess the quality and standards of practice in an independent health facility similar to what often is done by hospital accreditation, it may be necessary to look at the totality of the service being provided by all health care professionals in that facility. One might not necessarily want to tie the hands of any particular college investigator to looking just at the standards provided by the professionals they govern.

It may be necessary to look at the care provided, for example, by nurses in order to determine whether the instructions of a physician in the clinic have been properly followed through. It might not be appropriate to restrict assessment to precisely what the physician did and the physician's records without looking at the broader-based records of the facility.

We certainly appreciate the recommendations for expanding definitions in a number of other areas of the act and we are hoping we will be able to report back prior to or at the commencement of clause-by-clause with, if need be, some additional recommendations for further changes.

1110

Mr Lamont: I would only add to that that I would put it as clarifying rather than expanding. We accept the proposal of the definition for registrar. I think the other recommendations that Dr Baker put forward are clarifying or complementary.

Mr Sharpe: Okay. Thank you very much.

The Chairman: Are there any other questions from committee members? I know I cut you off, Mr Carrothers, or did you want to come in with another one?

Mr Carrothers: I think we have pretty well covered it, Mr Chairman.

The Chairman: Well then, thank you very much for making the presentation and assisting us with this important bill.

Dr Baker: Thank you. Good luck.

#### ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

The Chairman: Our next presentation is by the Royal College of Dental Surgeons of Ontario. Representing this body we have Dr Wesley Dunn, president and Dr Roger Ellis, deputy registrar.

Welcome to the committee. We have allocated 15 minutes for your presentation. Make your presentation, and if there are questions from the committee, hopefully you can deal with those.

Dr Dunn: It is a pleasure on behalf of the Royal College of Dental Surgeons of Ontario. If I take what Dr Baker says as being correct, that we are the second of the governing bodies appearing before you, I suppose by way of introduction I could say that much of what Dr Baker has commented on are the exact same concerns the Royal College of Dental Surgeons, as the governing body of a dental profession in this province, has as well.

I have four fairly brief points, and subsequent to that would be prepared to respond to any questions that may be posed. Again, we are limiting ourselves more to the technical areas that interface between the governing organization of a profession and the activities this bill embraces.

In our view, the act does not make clear which institutions and services are exempted. It should contain specific reference to exempted health facilities and services rather than be dealt with by regulation. It is appropriate, in our view, for the Legislature to decide on the fundamental exemptions; and one obvious exemption, if I interpret the statute correctly, would be the public general hospital.

I assume it is known to all here that the only dental services which are covered are those services which are rendered in public general hospitals, and they embrace some 22 or 23 oral surgical services. Beyond that, dental care is not an insured service in this province; so in order to have it an insured service, the dentist or oral surgeon must perform in a public general hospital.

Second, the act does not make clear whether health care professionals who provide noninsured services within an independent health facility are subject to the provisions of the act. If there is no intention, then the act should so clearly express. Section 2 seems to provide an exemption, but from sections 24 through 26 it would appear that they are included; so, like optometry, we are having some difficulty in the interpretation of the bill as it has been drafted.

Third, if a dentist or other health care professional who may share space in an independent health facility is subject to the provisions of the act, specifically with the ability of the minister to ensure the quality and standards of care, then again, in our view, a major overhaul of the sections dealing with the inspection process is required, and wherever standards of practice of the dental profession are involved, referral is made to the registrar of the Royal College of Dental Surgeons of Ontario.

The college is opposed to the assessment of standards of practice under regulations concocted under this act. This, we believe, is the historic role of the colleges.

We believe that an independent health facility, duly licensed, may well rent space to a dentist who would then operate a totally separate practice bearing exclusively on noninsured services. It should be clear that the powers of Bill 147 concerning inspection and assessment do not include reviewing that dentist's practice. If it is the intention of the Legislature to include in the review process independent contractors who share space, then major changes are required to insure the proper involvement of the self-governing bodies of the health care professionals who may share space.

Finally, the college has difficulty in interpreting section 24 in the light of section 2 and we urge amendments to the bill to make it clear that it is indeed the intention that dental services are not included.



The Chairman: Thank you for your presentation and thank you for leaving time for questions.

Mr Reville: You are indeed the second college; we have had two boards as well; the Ontario Board of Examiners in Psychology and the Board of Directors of Chiropractic. Some of the concerns they raised are identical to yours. One of the exchanges involved just this scenario that you posit, that a dental surgeon might rent space in an independent health facility. The answer given at that time by the officials of the Ministry of Health was that they would not be an independent health facility. You may want to hear that directly from their mouths, but that is what I thought they said on that occasion. So the mere renting of space as a contractor would not make this act kick in, but it would kick in if there were some kind of joint approach in which insured services and facility fees were contemplated being charged. Then you would be caught. It would not be impossible for that to happen either, I would think, for you people. I basically do not have anything else to say unless the ministry wants to add or subtract, clarify, deny, confirm or whatever, have lunch.

The Chairman: Do you have something you can add?

Mr Sharpe: I do not really want to add anything; I just want to confirm Mr Reville's comment. That is an accurate review of what I said at an earlier time. The services provided, if they were provided through the independent health facility with an add-on component or charge, where the practitioner was either a part of the ownership of the facility or an employee of the facility, would be caught by this bill and the parameters of the bill. But if it was simply a matter of renting space and there were referrals from the facility but the billing practices were that of the practitioner as a sole practitioner and a professional in his or her own right, then the bill would not affect what he or she did. They would not be caught by this act.

Dr Dunn: Could I seek one very brief clarification? As I understand what you have said, if the dentist is a totally independent contractor renting space in a facility, he would not be caught by this statute?

Mr Sharpe: That is correct.

Dr Dunn: If, however, that dentist wished, we will say, to purchase services such as a computer or accounting services or something of that nature, the practice would still be quite independent of this. But there is a business type of service that could be purchased. How would the act apply under those circumstances?

Mr Sharpe: I do not see that as being any different. My thrust would be that if the dentist had joined as part of the independent health facility and the billings were through the facility structure for the dental services, then there would be that added consideration for the add-on, adjunctive costs that might then be construed as a facility fee. But if there was a complete independence of practice and billing, the fact that some equipment might have been shared on a business cost-back arrangement, that would not alter what I said in terms of the individual being not caught by the act.

Mr Carrothers: Thank you for coming in. I am wondering if I could explore something here in the realm of what is coming to be called quality assurance. You have mentioned sections 24 through 26, which are the inspection sections, for want of a better word, of this bill.

I am wondering if you could give me an idea of what your college does to look at, inspect or assess the quality of service your members are giving to the public. Do you visit their offices from time to time? Do you respond to complaints? How does your college deal with that issue?

Dr Dunn: At the moment, the basic response is to some kind of complaint. If it is a formal complaint from a member of the public or someone else, there is invariably a procedure which is followed for every one of these complaints to bring the matter to some reasonable conclusion. Frequently they are settled at the complaints level. In the odd circumstance that a dentist is considered to be culpable to the extent that professional standards have been violated, then this matter, of course, is referred to the discipline committee.

There are procedures which are less formal than that and are provided for in section 40 of the Health Disciplines Act, which permit the registrar of the college, on reasonable grounds to believe that certain activities or certain diminutions of quality of care are involved, to establish a process to review that as well.

Then of course we have a review process we set up with three members of the college if the practice of a particular individual is particularly suspect. We follow it in that regard. Because of the activities of the health professions legislation review, we have been looking very strongly at this whole business of quality assurance and have a very active committee under the chairmanship of the former dean of the dental school at the University of Toronto, Dr Gordon Nikiforuk.

Perhaps at the moment we are not as sanguine as maybe our colleagues in optometry are in terms of mandatory continuing education. Some of us have spent an enormous amount of time on this subject and one of the great difficulties is that there seems to be a feeling out there that if you have a mandatory program in continuing education, automatically the quality of care the public will get will be better. There is one minor problem with that. There is not the slightest shred of evidence that that indeed exists.

But we are looking at this very, very carefully. We are aware of the tremendous problems in terms of site visits to dental offices, although this has been contemplated so that in any particular year there would be X number of dental offices visited. The records would be reviewed and if any concerns emerged from that, we would hope that appropriate action would be taken. But we have not gone that far yet.

Mr Carrothers: You could foresee the time, though, when you might just enter into a scheme where you are visiting randomly selected offices and looking at what goes on.

The issue of confidentiality during those inspections has come up and may not be quite as key in the type of services your members provide, but how do you deal with that? In that instance, it is that you have people looking at the dental practice and they might find out things about patients. Is that a concern or do you have any mechanisms to deal with keeping that confidential?

Dr Dunn: It is always a concern, but anyone who serves on our council and anyone who is appointed, and I now include members of our important executive and support staff, is pledged to confidentiality in terms of information which he is bound to acquire. One cannot, for instance, serve

on the complaints committee process without becoming privy to a lot of information. These people are honour-bound not to reveal that. Beyond that I do not think we can go.

Mr Carrothers: In these site visits—you used that term—that might get started, I got a sense that you already could do it. If the college had some feeling that there was a problem, you would visit, no doubt. That is, I take it, an informal one? You would call up and say, "We're coming," and so on. You would not just surprise the person.

In order to have that reasonable suspicion, do you have a process you go through? Do you get a search warrant? You just sort of visit, I guess. Would you proceed, meaning to establish reasonable grounds? That, as a lawyer, keys something in my mind which maybe I am reacting to. It is a hot word. Would you have a formal process or is it just an undefined suspicion you act on?

Dr Dunn: As I say, we act under section 40 of the Health Disciplines Act, which gives the registrar's appointees the opportunity to go and visit offices on reasonable grounds to believe. In other words, he simply cannot say: "There is a dental office. I think I'll go in and have a look at it." There must be some reasonable apprehension on his part to permit that.

Mr Carrothers: In his mind, I suppose, he establishes that, and once he is satisfied, he then acts. Is that correct?

Dr Dunn: That is correct. Dr Ellis, as the deputy registrar and registrar designate of the college, has been intimately involved in this, and he might add a comment.

Dr Ellis: A section 40 is actually a document which is signed by the registrar and given to the particular person, who then visits the office. It acts in essence as a search warrant.

Mr Carrothers: The registrar almost issues an authorization, in a way. He satisfies himself, and that is the vehicle that protects him.

Dr Ellis: And a report has to be given back to the registrar.

The Chairman: Any further questions?

Mrs Cunningham: Just one that I would leave with the group. A certain part of your profession does work with the government. Is that correct? There is work the Ontario Dental Association does with a contract through the Ministry of Community and Social Services for the government.

Dr Dunn: Oh, yes.

Mrs Cunningham: From time to time, the government has the right to go in and look at your individual records, whether it be services performed in hospitals, schools or wherever you would perform them. Is that correct?

Dr Ellis: The Ontario Dental Association refers any matters of complaints or suspicions or discipline to the Royal College of Dental Surgeons of Ontario rather than carrying out those inspections itself. It does not carry out a peer review or the actual inspections of offices.

Mrs Cunningham: My point is that the government from time to time, because you are spending government money, even though it has been contracted,

could in fact take a look at how you are spending the money. Is that correct, or do they not do that?

Dr Ellis: I am not 100 per cent sure of the answer to that question. I know the health units that do have clinics have inspections in another manner, but that is usually of the facility rather than the practitioner.

Mrs Cunningham: And the facility has certain records. What I am getting at is that if there were certain numbers of procedures done in the month of May, one would take a look at whom the procedures were done on perhaps, not the person but how many, and one has to document to get back the money that was expended.

I am just wondering if you have ever looked at that process around confidentiality, and I will leave it with you. It is a similar process that we will be looking at if this bill is implemented. Any information you could give us around concerns you might have—You may have to reach out into your clinic operations. You may have to speak to the people who do the negotiations with the Ministry of Community and Social Services to see if they have any concerns about that, for the want of a better word, audit process.

I am not aware that you would have any, but you may. If you do, it would be good information to pass to us, because that is the kind of thing the Minister of Health is looking at in the implementation of this particular bill around some concerns that have been brought before the committee around confidentiality.

The Chairman: Your time is almost up, but the minister has indicated she would like an opportunity to make one more point of clarification.

Hon Mrs Caplan: Just to clarify, and Dr Macmillan is here if there is a follow-up question, the question that Mrs Cunningham asked was if, as part of a physician who is working in a hospital providing an insured service—The Ministry of Community and Social Services either facility or program would likely be for those receiving family benefits, the children in need of protection program and that sort of thing.

Specifically, it is my understanding, and I want the college representatives to confirm if they would, that whenever OHIP has a concern about an inappropriate or potentially fraudulent billing practice by a dentist, OHIP refers that to the college, which does the assessment and investigation. Under this act, the proposal is identical except where there is a concern about a billing practice of an individual, as opposed to OHIP on behalf of the individual.

1130

Dr MacMillan: I think that is correct; that is how the system works.

Dr Ellis: That is correct.

Hon Mrs Caplan: So unless it is through a health unit or some other body which has a program on it, dentists or physicians working on fee-for-service are not subject to any kind of government audit; but if there is a concern about inappropriate or fraudulent billing practices, those are referred to the colleges of the practitioners.

Mrs Cunningham: My question is different. It is not about the



credibility of the physician or dentist at all. The question is very clearly around the program audit. When public money is being spent, there are certain documents that are gathered from time to time to make certain that if someone said he or she saw 200 children, let's say, in a particular municipality, in fact the person did.

That is the same kind of audit, inspection or whatever that would take place. In the government, it does not send people in because it is always concerned, but to improve the quality of the delivery of the program. Otherwise, during an audit people will say, "Well, yes, this is what we're getting the money to do, but times have changed and we'd rather do this." But in looking at what they do, patients' names are sometimes put forth. I am not saying it is or has been a major problem, but it is something we have to look at.

During any audit—and you may not have had any kind of audit in the last two or three years; I believe you have—there may have been some questions around confidentiality, as there have been from time to time. My point is that nothing has happened yet, but if we can build it into this act or other acts, I think it is an opportune time to do it, given that we are getting some input from the public.

I might add that the Group Health Centre in Sault Ste Marie does have some concerns around confidentiality, this very issue, which it will be sending to you. It was brought to my attention yesterday, and I did not ask the question today, but Helen Ross will be sending some information around their very large operation. It may assist us, that is all.

There would be no reason for you really to have that information at your fingertips unless you had been involved yourself. Maybe another member of your group has been.

Dr Dunn: The administration of the dental welfare program rests with the Ontario Dental Association. To the best of my knowledge—it is now my fifth year on the college—there has never been a communication from the ODA indicating any difficulty. If I am interpreting the minister correctly, I think you are making reference to the Dentistry Review Committee under the Health Insurance Act, when the general manager of OHIP will convey something: "I'd like to report to the committee. I don't know what this means exactly." But that committee has not been called to meet since 1982. It strikes me that if there have not been any manifest problems in seven years, it is not doing too badly.

Hon Mrs Caplan: The other issue Mrs Cunningham raises is the broader issue of accountability of transfer payment agencies. The Group Health Centre in the Sault was here this morning and would be, as are all health service organizations, community health centres and hospitals, into a relationship with the ministry where annual budgets are discussed in different ways. In fact, the Group Health Centre, for example, is funded on a capitation basis based on the roster. I would ask Dr MacMillan to comment on accountability of transfer payment agencies just so you know this is an issue totally separate from the issue that has been raised before this committee.

Dr MacMillan: All the transfer payments for health care dollars, of course, have to have a built-in accountability mechanism to see that tax dollars are spent appropriately. In doing so, any involvement of the government, with its audit branch or others involved, is sworn to confidentiality and not usually given confidential patient files in the course

of those inspections. While rosters may be checked and reasons for charges made, to my knowledge individual files are never privy to this type of audit of responsibility for transfer payments.

Mrs Cunningham: Just on that point, if you had had an abortion and your name appeared on a roster, that is a confidential document. You do not have to look at anybody's file. The point that was made yesterday and the day before was that perhaps that could be an initial or a number. There are other ways of presenting the information. Some agencies do it without being asked, and it is quite appropriate. That is what we are getting before the committee, and I am just sharing some information with you, because I have been there.

Hon Mrs Caplan: I am going to ask Gil Sharpe to respond to this one, because it goes much beyond the questions before this committee.

Mr Sharpe: It raises the issue, I believe, which Mr Jackson asked me to get into and on which we are hoping to report back very shortly, by the way, hopefully in writing. That deals with the matter of advising patients that inspectors will be having access to their records and what extra protections or precautions might apply in those circumstances, be it coding systems or some other means.

At the present time, as I am sure many of the committee members are aware, there are many not just ministry but government statutes under which inspectors operate, like nursing homes and all sorts of acts, where private files are viewed. The Health Insurance Act itself provides OHIP with the ability to see, for example, on the billing systems, whether an abortion was performed and the specific individual who had that service. There are special provisions now in the statutes requiring confidentiality, but the question is: Should there be perhaps additional protections?

We are also looking at the question of the Freedom of Information and Protection of Privacy Act and its possible application once the government has obtained personal data.

Mrs Cunningham: That is good.

Mr Sharpe: Of course, Mr Linden will be here to testify next week, but we are trying to put a more comprehensive view together for the committee in response to that question and hope to have something for you early next week.

The Chairman: I thank you very much for coming before the committee and sharing with us your perspective on this important bill.

Dr Dunn: Thank you very much for having us.

#### ONTARIO PSYCHOLOGICAL ASSOCIATION

The Chairman: Our last presentation this morning is by the Ontario Psychological Association. I would like to welcome to the committee Dr Ruth Berman, executive director, and Dr Warren Nielson, chair of the legislation committee. We have allocated half an hour for your time before the committee. You may make your presentation, and we would ask, if possible, that you leave some of that time for questions from committee members.

Dr Nielson: I would like to thank the committee for allowing us to appear before the hearings this morning. My name is Warren Nielson. I am a

member of the executive board of the Ontario Psychological Association. I am a psychologist at University Hospital in London. With me is Dr Ruth Berman, our executive director.

The Ontario Psychological Association is a voluntary organization dedicated to the advancement of the profession of psychology in Ontario and the betterment of the public, who we serve.

The association and the profession of psychology have long supported the principle of universal accessibility to health care services. Inasmuch as the proposed act has the potential to make health care services, including psychological services, more accessible to the citizens of Ontario, we endorse and support its adoption in legislation. None the less, psychological services are not universally accessible within the province. Community-based services are not covered by OHIP, thus, those who can afford to pay for these services privately receive them and those who cannot pay are excluded.

Although there are psychologists practising in many public hospitals, the services these psychologists provide are highly specialized and accessible only on referral by a hospital-based physician. For example, in my department at University Hospital there are 13 staff psychologists providing service to the transplantation, in vitro fertilization, epilepsy, rheumatology, neurology, general medicine, surgery and psychiatry areas. None of these psychologists is able to accept referrals directly from the community. In talking with my colleagues from various areas of the province, I have become aware that these restrictions are prevalent throughout Ontario.

A recent informal study conducted at the University of Western Ontario asked family physicians about the need for psychological services in our community. The overwhelming response was that there is a strong need, that they would very much like to refer to psychologists but that the services were simply not available.

Most public hospitals have psychologists on staff, because hospital administrations have recognized the need for psychological services and have elected to hire psychologists using moneys from their global budgets. Despite a 70-year history of health care provision in this province, OHIP does not specifically support services provided by psychologists, thus limiting the public's access to and choice of community-based services.

1140

Recent changes to regulation 518 under the Public Hospitals Act have further restricted accessibility to psychological services. This regulation now prohibits anyone other than a physician from registering outpatients in a public hospital, so even if services were made available to community physicians who would like to utilize hospital psychologists, it would now be illegal for psychologists to accept referrals.

We would hope that the Independent Health Facilities Act would increase community accessibility to health services provided by psychologists. We are concerned that as the government shifts health care services from institutions to the community, psychological services will continue to be available to the citizens of this province and will be more widely accessible.

Many of these services involve health care, broadly defined, and not simply mental health. Chronic pain management, health maintenance and illness prevention, rehabilitation of brain-injured persons and facilitation of



adherence to medical regimens are but a few of the areas in which treatment programs have been developed and are provided primarily by psychologists.

At present this bill appears to address only those services provided by physicians. It is our belief that this act should be consistent with the ministry's present philosophy aimed at expanding community-based services, which assumes a more multidisciplinary focus. While we support the establishment of independent health facilities, we believe it is essential that psychological services be permitted under the act.

We would like to see the planning for such facilities done at the level of the district health councils. Under the present provisions, initiatives are generated centrally by the Ministry of Health. We believe that district health councils are often much more attuned to the needs of individual communities than a central organization can be. Thus, while the director of independent health facilities and the Minister of Health should oversee the planning process, Bill 147 should allow local initiatives as distinct from ministry-based funding priorities.

Currently the district health council members are appointed rather than elected. Given their potentially increased scope of responsibility under Bill 147, we would like to see these individuals elected. This change would better allow fair representation of the wishes of the public as well as accountability for decision-making. We feel elected representation is especially important in this time of budgetary constraint and given the difficult choices which must be made with respect to resource allocation.

Bill 147 contains provisions for quality assurance. As psychologists, we endorse the view that health service providers should be accountable for what they do and how public moneys are spent. However, we are concerned that under section 26 of Bill 147 patients' rights to confidentiality may be violated. We do not feel it would be appropriate for government inspectors to have free access to patient records compiled by psychologists. Such information is typically highly personal and given to the psychologist with the understanding that except under extreme circumstances, for example, potential suicide or homicide, confidentiality will be maintained.

Patient confidentiality is essential to the practice of psychology and free access to records by external agents would significantly compromise service delivery. Moreover, the practice of psychology is governed and regulated by the Ontario Board of Examiners in Psychology, which prescribes standards of care, including maintenance of records, to which all psychologists must adhere. Further regulations pertaining to patient records are unnecessary. Hence, we would like to see this provision of the proposed act deleted.

In general, we feel that this bill is ambiguous and confusing. The roles of various key players, such as directors, assessors, registrars, inspectors and the ministry, are unclear. It would appear that many details which should be discussed in public hearings are being left to be dealt with in the regulations. As you know, regulations can be changed by the government without consulting the Legislature. We do not believe that the cabinet should have broad regulatory control over such issues as determination of health standards and decisions as to who should be allowed to access patient records without patient consent.

Psychologists have been independent professionals as recognized in law under the Psychologists Registration Act since 1960. Where psychological



services are provided in the context of an independent health facility, inspection and quality assurance with respect to psychological services should be the responsibility of the Ontario Board of Examiners in Psychology.

In summary, the Ontario Psychological Association supports the principle of increased access to community-based health care services. It is our hope, though, that this bill will allow for a broad range of health care services in order to meet the entire spectrum of health care needs and ensure a high standard of care for citizens of Ontario.

The Chairman: Thank you for your presentation and for leaving some time for committee members to ask questions. I will begin with Mr Carrothers.

Mr Carrothers: You have raised the issue of inspections and confidentiality so I would like to explore that some more if I may. You have mentioned in passing that you yourself work in a hospital and carry out your practice within a hospital. I guess I am wondering, that is obviously an accredited institution. It is inspected in some fashion—there is a body that accredits them. What happens now with your records and who can look at them, and to what extent can they do that?

Dr Nielson: Our records are actually kept in two places at this stage. We have departmental records which can only be accessed by a psychologist or in some instances can be subpoenaed by the court. Our records are also, in part, part of the medical record, so reports that we write and in some cases progress notes become part of the general hospital health care record.

Mr Carrothers: If the hospital is looking, as I am assuming it might, it must have some sort of internal quality control. It must look from time to time at what happens within its facility and then this accreditation body comes in. What records do they look at when that happens? Do they look at both sets of records? How does it happen in practice when someone comes in to see what has been going on and to find out what has happened, the quality and so on?

Dr Nielson: I know that those accreditation committees can look at our records. In our department we have not had any experience where they have actually elected to do that.

Mr Carrothers: I see.

Mrs E. J. Smith: But they can.

Dr Nielson: They can.

Mr Carrothers: They can now and you have not had any problems where none comes in. Have you heard any of your other colleagues at other hospitals? Have they commented on difficulties in that regard—had their records looked at in terms of the accreditation and inspection process of a hospital?

Dr Nielson: No, it has only been recently that these accreditation organizations have looked at departments of psychology. I am just thinking of the last couple of years, so it is a fairly new experience for us.

Mr Carrothers: There are the examiners—what is the official name of those; the body that accredits psychologists? What does it do and how does it handle that issue? If they are coming in, do they assess from time to time the

work you are doing in any way, and if they do, how do they deal with the question of confidentiality?

Dr Nielson: They set standards for psychologists and psychology departments, providers of psychological services, in terms of how long we have to keep records and what types of information must be kept in the records. Each psychology department is responsible to ensure that those standards are met.

Mr Carrothers: Does the body of examiners ever come in to see that it is done?

Dr Nielson: They only respond to complaints. They do not go into each hospital.

Mr Carrothers: It would probably not be that that record has not been kept but for other reasons then?

Dr Berman: I do not know that the Ontario Board of Examiners under the current Psychologists' Registration Act is empowered to go in and inspect a psychologist's record unless there has been a complaint registered. I could elaborate a little bit more on what Dr Nielson said. Prior to my being involved with the association I worked in a hospital as well in a psychiatric facility. I concur there is a dual recordkeeping.

The psychologists who assess an individual will store what is called the raw data, the assessment information, in a separate psychology file that is accessed only by psychologists and those who are working under the supervision of a psychologist. The psychological report that is written following an assessment is placed in the health care record. The record can be accessed by other health care providers who have a need to know and who are involved in the care of that particular individual. As far as I am aware, committees that have come to accredit the hospital have not examined the psychological records to date.

1150

Mr Carrothers: Just to understand it, you mentioned the term "psychological report." Would that be almost a formal opinion on the patient that is forwarded into the medical record?

Dr Berman: It is the concluding opinion of the psychologist depending on what the referral question was, based on his interview, history, psychological test data and so on.

Mr Carrothers: Then the other record is raw notes, the kind of scribbles you make as you are talking, that sort of thing?

Dr Nielson: I might add that we discuss with each patient, before we send anything to the medical record, what exactly we are going to send. We are bound to do that in order to protect the individual's confidentiality. So they are not always identical; the information is not just raw data within the psychology department. There is sometimes other information that the patient does not wish to be generally available.

Mr Carrothers: I have just one final question. If I have understood some of the proposed amendments to this legislation, it would be people from the board of examiners who would go in to look at records. Have I got that

correct? There would be people involved in this area who would be looking at those records, your own set of records, if you will, not the institution's record.

I am assuming that if you were involved in one of these independent facilities, the same duality would exist. There would be sort of a personal set and then the official set or the institution's set. Does that give you any comfort in terms of confidentiality? In the way of a purpose, presumably it would be in terms of the quality of the psychological services you are rendering that they would look at it.

There are other issues that are financial, but I would assume those sets of records that you keep would not have that, so people would not be looking at it. If you are looking at what the institution is doing in its various aspects, which does not obviously include its financial dealings, those are not going to show up in your records. They probably would not have any financial information in your records, would they?

Dr. Nielson: That is right.

Mr. Carrothers: Unlike a practitioner who is billing a fee-for-service situation, the record is likely to have a notation and so on of billings. You are not doing that or do not do that.

Dr. Nielson: Right. I am just not sure how that would work in an independent health facility, for example.

Mr. Carrothers: Probably the same as a hospital, I would think.

The Chairman: I would like to move on to Mrs Cunningham for some questions at this time, and then I would like to leave some time for a ministry clarification.

Mrs. Cunningham: Actually, that may be the essence of my questioning: some ministry clarification. I will ask the witness if the question has already been asked. I apologize for leaving; I apologize for not being here.

My questions have to do with your concerns around being able to set up an independent health facility that would provide psychological services, especially as it relates to some of the patients you described, and epilepsy, psychiatry and the list you made. It is my understanding, and I am not sure whether you have had any further communication with the ministry, that this would be quite possible—the minister could perhaps elaborate when she is responding—that you do not need a physician to set up this clinic. That was the kind of information we shared back and forth yesterday, so when I first went into these hearings, I was wondering if that was possible as well.

The other clarification we had was that capital dollars are something you can negotiate with the ministry around this bill. If I am incorrect, I am sure I will be corrected, and that is fine.

My question has to do with this deletion. I am following up on what Mr Carrothers was chatting about, because I think all of us are interested in confidentiality. He talked about the notes you would make. It was never my understanding that for any reason anybody would have to look at the notes. I am wondering if in your instance, in the work you do, maybe just the name and the service you are providing, whether it is a counselling service or whether it is around whatever kind of counselling, maybe that in itself would be intrusive. I just wondered if you would respond to that.

Dr Nielson: I agree that it could be. I believe the patient should have a right to decide whether or not his name is released in the context of having psychological services.

Mrs Cunningham: Right now, if someone wants psychological services and is referred and goes looking for a psychologist, for educational reasons or family matters, are you saying he can only get that service if he is in a hospital?

Dr Nielson: They can only get that service if they go to clinical psychology services, if they go to a hospital on the referral of a physician, usually a hospital-based physician, not a family physician, because family physicians are not typically allowed to refer to psychology departments directly; or they must pay out of their pockets to see a psychologist in private practice. Those are their two alternatives at present.

Mrs Cunningham: So you are looking forward to this bill, obviously?

Dr Nielson: We think it has the potential to allow greater accessibility to psychological services for the citizens of Ontario.

Mrs Cunningham: I have noted your ambiguous and confusing statement.

I am interested in the district health councils and your going so far as saying that they should be elected. That is an interesting viewpoint. Have you had a lot of opportunities to work with district health councils?

Dr Nielson: Not personally. There are psychologists in our association who do work on district health councils. Our feeling is that if district health councils are going to be more involved in this process, there should be elected public representation. If they are appointed, that allows other types of problems to enter in terms of how these people are appointed and that sort of thing.

Mrs Cunningham: It all has to do with accountability really, does it not?

Dr Nielson: Yes.

The Chairman: Are you aware of a recent change whereby the municipal representation on district health councils is now being shifted to the elected members of the council rather than citizen appointees?

Dr Nielson: No. We are very happy to hear that, though. We would like to see that principle extended.

Hon Mrs Caplan: There were a few issues raised which required ministry clarification. I am going to ask Gilbert Sharpe to address those. As well, I am going to ask him if he would put on the record what exists today under the Mental Hospitals Act and the Public Hospitals Act regarding the issue of quality assurance and inspection as it regards the ministry specifically and the board of psychologists.

Mr Sharpe: There are several legal issues raised in your brief, in your presentation and by members of the committee. I thought I would begin with the question of whether psychologists could be funded under this mechanism autonomously from physicians in clinics operating in the community.



The existing structure, of course, is tied to the provision of insured services under the Health Insurance Act, so that there would have to be a regulation change under that statute to include psychology within the concept of other practitioners under that act, not necessarily on a fee-for-service basis in the schedule of benefits but somewhere under the regulation funding mechanism under health insurance. If that were done, then psychology as a community clinic practice standing by itself could be funded through an independent health facility licence under this act. But under the present scheme of the Health Insurance Act that would not be possible.

The minister, I believe, earlier on referred to the work that is being done on a community mental health act. It may be that eventually when that legislation proceeds there would be an interrelationship between the services mandated under that structure and the funding mechanisms and vehicle through this legislation, with appropriate changes being made to the rates under the Health Insurance Act. That was one issue.

There were several others you raised. First of all, let me deal with the Public Hospitals Act and the Mental Hospitals Act issue on inspection powers. As I am sure you are aware, many services now being provided by psychologists are in mental health settings, institutional settings, to a large extent. Those facilities are governed by statutes like the Public Hospitals Act—the psychiatric units of the hospitals would fall under that statute—or the Mental Hospitals Act, the 10 government-run mental hospitals, like Queen Street Mental Health Centre and so on.

Under those statutes, there are inspection powers—the minister would be expected to have people go in and inspect from time to time—and the authority of those inspectors to look at all records including the medical records in which would be contained information from a number of sources including, as you have indicated, reports from psychologists that would contain very confidential information.

1200

Of course, those inspectors are under an obligation of secrecy. I do not personally know, in recent history, of any particular concerns that have been raised about inspectors breaching confidentiality but, as I indicated earlier today, that is an issue that is being explored. I hope there will be a report that we can have on the table very soon for this committee.

On the question raised on page 2 of your brief, which we have heard from a number of sources, you are referring to a regulation change made under the Public Hospitals Act several months ago which some are interpreting as having the effect of removing the ability of nonphysician practitioners to register outpatients in an autonomous fashion. That is being portrayed as a change.

In fact, that was neither the intent nor, in my view, the effect of that regulation change. The provision in the regulation speaks of all patients being admitted under the authority of a physician. The notion of authority is reflective of the medical model under which public hospitals currently operate, that ultimately there must be a physician—it may ultimately be the medical director—who must be responsible for the care and treatment of patients and outpatients of any facility.

It is similar to the provision in the mental health regulations, under the Mental Health Act, requiring a psychiatrist be in charge of the care and supervision of patients. It does not mean the psychiatrist-in-chief need see

every patient who is admitted or registered to a facility.

Briefly, just to summarize on this rate change: It simply codifies the notion that the medical director of a hospital is responsible for all the patients in the hospital's care in setting standards and guidelines and so on, but the actual registration of outpatients can continue to be done by psychologists, chiropractors or by whichever groups have always looked at outpatients in facilities in an autonomous fashion from the physicians themselves. In other words, a physician need not actually see and personally assess every outpatient in the hospital, although a physician is ultimately responsible for directing patients' care and setting the rules, bylaws, regulations and so on under which that care is delivered.

Dr Nielson: The problem with that is that in most public hospitals, psychology departments are independent and some of the services they provide are totally separate from any sort of medical involvement. We have anxiety disorder clinics and alcoholism rehabilitation clinics and there are no physicians involved. There are no physicians who look into the running of them on a day-to-day basis or on a year-to-year basis.

You are saying that a physician should be overseeing these things but in practice that has never happened in many of the areas in which we practise in hospitals. It has been very confusing to us.

Mr Sharpe: You are correct. I know in practice that is the case but my understanding of the bylaws that have been enacted under the Public Hospitals Act is that they do currently reflect the notion of the medical model where a physician ultimately is accountable and responsible for the care of all patients and outpatients. In practice that often is not done and maybe some of those linkages have broken away, and legitimately so.

However, the minister, earlier on in the committee hearings, referred to a couple of initiatives: the amendments that are ongoing now that are being worked on in the consultation stage of the Public Hospitals Act and the health professions legislation review. Both of these exercises will examine the proper role for nonphysician practitioners—their scope of practice, standards and so on and licensed acts, that entire scheme that has been developed under the health professions legislation review—and then the parallel issue under a new Public Hospitals Act as to whether autonomous physicians, and if so, which ones, should have access to admitting privileges and registration privileges for the services of hospitals.

It is a very fundamentally important issue that is being examined, but at the present time we have the old Public Hospitals Act, which still does reflect the medical model, and that was really the principle embodied in that regulation, which was simply meant to reinforce and codify the ultimate responsibility of the physician in the hospital system.

Hon Mrs Caplan: If I may, I think the explanation that Mr Sharpe gave is an excellent one and a legal one. What it also points out is the enabling ability of this framework legislation to respond to the issue that you raised, which is outpatient practice as opposed to the kind of service that requires in-patient facility and in fact the—

[Failure of sound system]

Hon Mrs Caplan: —in place. So this framework legislation will enable the kind of community based services which formally were only found in

the hospital, in the public hospital environment where you have all of the quality assurance, the responsibility of the medical advisory committee, the responsibility of the administration for quality of patient care. This will allow for services to be provided with the same quality assurance in a community based setting. As we have heard from a couple of the colleges today, most of them act only on a complaint in a private practitioner's office. So, it was very, very difficult when you looked at only the hospital or the private practitioner's office and you never had enabling or framework legislation to allow for that community based alternative for services that could be provided in a quality assured environment.

I am pleased to have the opportunity—I think this change really talked to the opportunity—that this legislation holds for appropriate delivery of services in an appropriate setting with the kind of quality assurance which presently exists under the Public Hospitals Act and the Mental Hospitals Act for the delivery of mental health services, both psychiatric but as well particularly psychological since the insured service concept under the Ontario health insurance plan act allows for psychiatric services, that psychological services are provided in alternative ways at the present time.

The Chairman: I am conscious that some portion of your time towards the end has been used for ministry clarification so I am prepared to be flexible and give you some time for concluding comments or anything you wish to add.

Dr Nielson: We would be very happy to work with the ministry on the Public Hospitals Act and on any other bills affecting psychology. Our biggest concern is that psychological services continue to be available as the government shifts its emphasis from hospital based services to community based services.

The Chairman: Thank you very much for your presentation today and sharing with us your thoughts on this important piece of legislation.

Members of the committee, this concludes our schedule of delegations for this morning. We will reconvene at 2 p.m. We have a fairly full afternoon so I would ask that you would be here at that time if possible.

The committee recessed at 1207.

CAZON  
XC12  
-578 ..

STANDING COMMITTEE ON SOCIAL DEVELOPMENT  
INDEPENDENT HEALTH FACILITIES ACT, 1989  
THURSDAY 17 AUGUST 1989.  
Afternoon Sitting





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Epp, Herbert A. (Waterloo North L) for Mr Daigeler

Hosek, Chaviva (Oakwood L) for Mr Beer

Matrundola, Gino (Willowdale L) for Mrs O'Neill

Philip, Ed (Etobicoke-Rexdale NDP) for Mr R. F. Johnston

Reville, David (Riverdale NDP) for Mr Allen

Smith, E. Joan (London South L) for Ms Poole

Clerk: Decker, Todd

Staff:

Drummond, Alison, Research Officer, Legislative Research Service

Witnesses:

Individual Presentation:

Matheson, Barry, appearing on behalf of Dr Bruce Lennox

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriole L)

MacMillan, Dr Robert, Executive Director, Health Insurance Division

Sharpe, Gilbert, Director, Legal Services Branch

Individual Presentation:

Lipsitz, Dr Jeffrey

From the Ontario Hospital Association:

Tuck, Dr Dennis, Chairman

Short, Hilary, General Manager, Public Affairs

Goodfellow, Colin, Policy Analyst

Individual Presentation:

Brown, Dr Harry

From the College of Physicians and Surgeons of Ontario:

Dingle, Dr Brian H., President

Dixon, Dr Michael E., Registrar

From the Coronation Health Centre:

Assad, Bonnie, Business Manager

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 17 August 1989

The committee resumed at 1413 in room 151.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: The meeting will come to order. I would like to welcome members of the committee and observers and delegations coming before us this afternoon. This is a meeting of the standing committee on social development, convened to consider Bill 147, An Act respecting Independent Health Facilities. We are into our fifth day of hearings. This afternoon we have a fairly full agenda.

Our first delegation is Barry Matheson of the law firm of Sullivan, Mahoney, barristers and solicitors. I would like to welcome you to the committee. We have allocated 15 minutes for your presentation, and committee members usually appreciate it when delegations leave some of that time for questions.

BARRY MATHESON

Mr Matheson: Mr Chairman, Minister, members of the Legislature, I appear on behalf of Dr Bruce Lennox, who is a physician in the Niagara region. His curriculum vitae is attached as schedule 1 to my submissions and I will not refer to them. As you can see from the curriculum vitae, he is very active in the medical profession with respect to education and also in the practical application of his profession.

For a number of years, he has been organizing and assisting the Niagara Academy of Ophthalmology. I enclose here a schedule 2, which is the next annual meeting in Niagara-on-the-Lake, starting on 17 November of this year. The number of physicians involved in this field is great and the areas that are covered are very intense. I believe it would not be an understatement to say that this academy would not be off the ground without the major assistance of Dr Lennox.

I have been able, along with Dr Lennox, to go over thoroughly the proposed Bill 147, and we feel this bill takes tremendous strides to provide better and cheaper health facilities to the citizens of Ontario.

There are a few practical items I would like to address. The first item is the question that the independent health facilities will be nonprofit facilities. We concur with that feeling but have taken the liberty of preparing a cost schedule that would show the amount of money an individual or group of individuals would have to come up with in order to provide this facility.

Attached to this as schedule 3 is a financial estimate to carry on services in an independent health facility unit for laser and cataract

surgery. If I may, I would like to draw the committee's attention to some of these figures that show on schedule 3. We have gone through the various capital costs of the equipment and that would be approximately \$297,000. The construction costs would add an additional \$240,000, in addition to the land.

We have also worked out the cost savings to the citizens of Ontario and with those costs that have been set out on pages 2 and 3, we feel a cataract operation would come in at about \$954. If we compare that to a hospital setting of an inpatient procedure, it is approximately \$1,400. If we do it as an outpatient, it is slightly higher. In our figures, we have estimated there would be cost savings to Ontario of approximately \$400. We also believe it would be able to provide better facilities in this type of a setting.

That being the case, and these new health facilities will be very expensive, we still will be able to provide lower costs and more effective delivery. With this amount of money invested, the concern of anyone's getting into the field is section 10 of the bill, which says, "A licence is not transferable." If a licence were not transferable and the building were built specifically for an ophthalmological unit, and if the doctor retired, became incapacitated or for whatever reason were not able to continue, then he would have a facility that he would not be able to sell for the amount he or she invested. Would the committee consider altering section 10 of the act to say that the licence is not transferable other than with the consent of the minister?

With respect to section 11, "Every licence expires on the date specified on the licence, which shall not be later than the fifth anniversary of its issuance or renewal," as we have indicated, the costs of these facilities are high. When one is dealing with banks and trust companies—because we are not looking to government for grants or subsidies—from an economical point of view it would be easier, in the financing of these facilities, if the period could be increased from five years to one of seven years.

With respect to section 7, I would draw to your attention that my client, Dr Lennox, has been doing laser surgery in his clinic since September 1985 and has been so recognized by the ministry. One of the reasons he is using his clinic is that he has been able to obtain better and more up-to-date equipment. Dr Lennox has also been doing cataract surgery, but in a hospital setting. He is of the belief that he would be able to accomplish both at an independent health facility unit and that they would be compatible.

I would suggest that section 7 could be modified to allow people or doctors who are eligible to apply to the minister in one area—in this case, as far as Dr Lennox is concerned, in laser surgery—if they have been doing work that falls within the ambit of the Independent Health Facilities Act, but in a hospital unit, that they be extended the same courtesy and allowed to apply directly to the minister as well. Under these circumstances, if one were allowed to apply directly to the minister rather than to the regional health council, it would expedite the introduction of the facility to the public.

1420

In summation, we feel that under the new proposed legislation, the physicians in Ontario would be able to react more swiftly to changes in technology and also changes with respect to items purchased, from drugs on up.

There are a number of drugs my client has tried to get through the hospital facilities, but it sometimes takes up to a year to a year and a half

in order to get these items dealt with. For example, one of the drugs he has tried to get is a substance injected into the eye before surgery that will render the procedure safer and will assist in the implanting of intraocular lenses. Attached hereto is schedule 4, which outlines the cost savings.

If you could just look at this, this is a viscoelastic agent. There are two products available. One is Healon and the other one Vicsoat. They are basically the same price, but we need to use two units of Healon, or \$60 a procedure, as opposed to Vicsoat, of which you use one. There is a saving of \$30 a procedure. He has estimated that the savings to the taxpayers of Ontario as far as his practice is concerned would roughly be around \$30,000.

A physician has a choice of a number of drugs that may be used prior to or during an operation and we have selected the one drug I have just referred to.

We would like to compliment the ministry for a very innovative act and I am sure that Dr Lennox and other doctors in the same position will co-operate in the fullest to see that this is implemented to the benefit of the citizens of Ontario.

The Chairman: Thank you very much for making the presentation on behalf of your client, Dr Lennox, and for leaving some time for questions from committee members. We will begin with Mr Carrothers.

Mr Carrothers: I appreciated this presentation, particularly schedule 3. That has been very interesting and informative. I do not think we have had that kind of information before us in terms of the details of the costs.

I wanted to talk a bit about your comments relating to section 10 and the transferability of a licence. One of the concerns I have is that a licence become a commodity with value attached. I am not sure it is good in the public interest that that take place. I understand what you are saying in terms of the amounts of moneys that have to be raised and security given and so on in order to get an operation like this off the ground. I guess what I want to explore a bit with you is why having the licence transferable would make that much difference.

When I look at schedule 3, I see, as you mentioned, that there is about \$297,000 in costs of equipment, I guess.

Mr Matheson: Yes.

Mr Carrothers: I would assume that equipment wears out fairly quickly. It has been my experience most equipment seems to wear out. You seem to replace it every five years or so.

Mr Matheson: Dr Lennox just purchased one item for \$100,000 and there is a unit over in France that he can get for just under \$1,000, so his piece of equipment is now obsolete.

Mr Carrothers: Maybe this is the point I am making. We have a situation where you get a five-year licence for the facility. The costs and so on are basically agreed for that five-year period, which would include, as I have understood what we have heard from the ministry, these kinds of costs and so on, probably coming out to a kind of a facility fee relating to the sort of costs you have outlined in F here, although I am wondering if you have



depreciated your buildings over five years or longer, but I am not sure that is important.

If you have a licence for five years, with that kind of income flow it would seem that you could indeed secure the financing. I guess I wonder why you would have to have a transfer of a licence in order to sustain the business interests. It seems to me the professional practice is something you deal with and sell without transferring a licence. Why would you need it in this case?

Mr Matheson: Dr Lennox has travelled extensively throughout the United States and has looked at these similar units down in the US. They are designed specifically for this type of surgery, plus related eye care treatments. The building would be specifically designed for that.

We are certainly not suggesting that we have put a price tag on the licence, because I, as the former chairman of a hospital, would find that awful. It just would not sit well with me, nor do I think it would sit well with anybody else. What we are suggesting is that it could be transferable but with the approval of the ministry, and then possibly the person or persons who obtained the licence could take over some of the building, but at cost.

Mr Carrothers: If the building is specifically built for this purpose, and I am assuming there is a continuing need so that the new operator would want to come in and operate and would do so at the premises, would they not just want to buy the value left in the facility and get a new licence? I am just wondering why sell the licence or transfer it? The minute you have a transfer, it seems to me you then talk about a sale and you then automatically, because they are in scarce supply, start to get a value attached to it, which is what I am concerned about, and I am glad to hear you are as well.

I wonder if all the other financial needs are not met by being able to transfer any residual value. A new operator would want to operate in the area, take over this very specific facility, if that is the case, because I am sure in other types of facility you would just be running normal office space which could go into another use if the place closed down, but I can see in this case there might be a specific problem. Would they not just buy the building and carry on?

Mr Matheson: They might. There is no guarantee. Looking at the financing, we have estimated that it would cover the cost within five years. That is why we have asked this committee to consider increasing the length of the licence. We have also suggested the other because it would just make it a little bit easier to raise the financing because it is going to be private moneys and not government moneys.

Mr Carrothers: From what I have heard it could be a mixture. I think the government has indicated in the discussions of what it is going to flow that it would be dealing with it, but it may be that the upfront money comes from private sources. You are saying seven years. Is there a magic in that number, rather than five?

Mr Matheson: I do not think there is magic in the number five either. In looking into this matter, it has been shown to me and to others that a five-year period is just a cost recovery time. The other two would just

make it that much easier to arrange the financing, maybe at a lower interest rate. That is the reason we are discussing that.

The Chairman: Mr Carrothers, I think we should move to another member.

Mr Carrothers: I appreciate that.

The Chairman: Thanks for your questions. Mr Jackson.

Mr Jackson: I appreciate the detail and the amount of work that has gone into this brief.

Mr Matheson: Thank you, sir.

Mr Jackson: It begs the first question that perhaps the minister could respond to later, and that is the extent to which the ministry has looked at these kinds of models. I would be interested in getting some response. But they have not been shared with the committee is what I want to tell you, so in this sense that you have now given to us, we appreciate that. The extent that the minister had these kinds of models to look at was one thing, but we had not seen them until you brought one forward. I wanted you to know that and I thank you for the work that has gone into that.

We certainly cannot miss the opportunity with the minister present to ask if she would look into this on behalf of your client's plea in schedule 4, for efficiency and cost-efficiency, to switch from Healon to Vicsoat at a savings to Hotel Dieu Hospital, and if that is still unresolved, perhaps the minister would be willing to examine why that is happening.

Mr Matheson: Mr Jackson, I do not want to get into an argument with the minister and I do not want to get on her wrong side.

Mr Reville: That is quite wise of you.

Mr Matheson: Pardon me?

Mr Reville: Very wise of you.

Mr Matheson: Yes. As I have said, I have been a hospital governor for 21 years and I have been chairman for five, and no matter which hospital—it was not at the Hotel Dieu; it was the other hospital in St Catharines—when a doctor comes in with a proposal, it has to go through various committees, and you can see the various committees, before it is decided upon. I am not taking a shot at any hospital. It is just the procedures that have to be followed, because if hospitals purchased every drug or every piece of medical equipment that doctors suggested, that would be cost-inefficient as well.

I am using this one example to show that people in private practice who are running their own unit could have tremendous savings both to the public and to the ministry. I just use that as an example. There are others.

1430

Mr Jackson: I will leave that for the moment. I appreciate the insights that you give us to take us off of looking at the sale of the licence as a form of legal barter but rather as something which strengthens your

bargaining position when possibly transferring the ownership of your clinic as it stands. You have really brought some insights to that, but you hinge that on the notion and the request to us of modifying section 7 to bypass or also have access to the minister directly to apply for a licence.

Maybe the ministry could react to that request as to why the legislation only allows for the ministry to put out proposals or for the district health council to put out requests but, as you have indicated in your brief, does not allow you to approach the DHC and the minister directly and request. Could we get some reaction to that? I want to better understand that.

Hon Mrs Caplan: To be clear, anyone can approach the ministry and the minister to identify a need. The process we envisioned is that the ministry would then contact the district health council to say: "In your district, in your region, this need has been identified. We would like your advice." The district health council would then advise as to whether it felt a request for proposal should be issued based on what services were provided in the community. That would be one way that a proposal call could be initiated.

Another is where the ministry identifies the need and goes to the district health council and says, "We have identified this need, independent of anyone making representation to us, from our own survey of issues." Again, the process would kick in.

A third way would be for anyone to approach the district health council and for the district health council to identify a need and make recommendations based on its assessment. The district health councils are advisory to the minister and the minister would review the recommendation of the district health council and would proceed appropriately, either to call or not to call for a request for proposal.

Mr Jackson: I will leave it at that, but simply say that I get a sense from your brief that you are talking about a timing issue here—

Mr Matheson: Yes.

Mr Jackson: —and that what the minister has described is a willingness and an openness to receive proposals from both tracks, but ultimately everything gets puts back on the main track with the district health council in terms of approvals. Otherwise you would have the district health councils spinning their wheels while you decide within the ministry that this proposal shall be given preference. That does not address the points you have raised for this committee, and you may wish to react to that, which is that these processes may take a considerable length of time. Meanwhile, accessibility points for Ontario's health needs are not being encouraged; they are just being put off for a little while longer.

Mr Matheson: I will use another example. When we were trying to get the computerized axial tomography scanner for the Niagara Peninsula, some four or five years ago, it took us approximately three years. That was with the co-operation of all nine hospitals. It had to go through the Niagara District Health Council and then to the ministry on up. Maybe it was a little more than five years ago. There was a time factor. In this particular case of Dr Lennox, he would qualify under subsection 7(1) of the act to apply directly to the minister for his laser surgery clinic and would not have to go through the Niagara District Health Council.



Mr Jackson: Because he would be grandfathered. He has an existing clinic.

Mr Matheson: Yes, but at the same time he is also doing cataract surgery in the hospital settings. So if he were granted permission to get the clinic for the laser surgery, he would then have to go through the Niagara District Health Council for a compatible service. That may take up to whatever time frame, a long period of time. He would then be operating in a clinic, if he were granted that, and then he would have to do other operations in the hospital setting. He may never get the approval to do cataract surgery in an independent health facility unit. That is the situation that Dr Lennox faces.

Mr Jackson: I understand it now. Thank you.

Hon Mrs Caplan: The other thing is that, as I understand the process, the role of the district health council will be laid out through regulation. But the intent of the bill is to allow the minister, when a need is identified because of emerging new technologies, either where there would be a provincial resource, and therefore not specific to any one district health council area, to set up a process similar to the process we did on the lithotripsy, which I know the member is so interested in, where you are looking at a provincial resource, or also in a situation where there might be a more pressing need. Because the act does not specify a process, the minister has the flexibility to be able to respond appropriately.

The Chairman: Thank you very much for your presentation. I think the exchange has been helpful and the committee will consider your input at the time of its deliberations.

Mr Matheson: I appreciate that.

#### JEFFERY LIPSITZ

The Chairman: Our next presentation is by Dr J. Lipsitz. I would like to welcome you to the committee. We have allocated 15 minutes for your presentation. You may wish to leave some of that time for questions.

Dr Lipsitz: Thank you. I am a general practitioner practising in north Toronto. First of all, I want to express my appreciation for having the opportunity to address the committee and present my own personal views.

The stated aim of Bill 147 is to "move towards broader-based community health care." I am concerned that the reality will be very different and that the bill as presently drafted could lead to the restriction of medical services to the elderly and other patients who most need them. I believe this would be the inevitable result of the proposed overregulation and, hence, limitation on practitioners and nonhospital-based or so-called independent health care facilities.

In a backgrounder to the Independent Health Facilities Act, 1988, the Ministry of Health indicated: "The ministry wants to ensure that independent health facilities are appropriately located and that procedures are performed in a safe, effective manner. The act will regulate the delivery of services and assure quality of care and standards."

I would like to comment on the ministry's stated objectives. The ministry intends to determine the appropriateness of the location of an independent health facility. The examples cited by the ministry always relate



to the establishment of independent health facilities in locations where services are now lacking, but this act empowers the ministry to force closures of existing facilities in locations that the ministry deems inappropriate. Why can this not be left to market forces of supply and demand?

The ministry loves to say that physicians churn the system by artificially boosting demand for their services and therefore argues that the forces of supply and demand alone are unreliable. Even if we were to accept this unsubstantiated allegation, surely this could never be a significant factor with respect to the very specific and specialized services that an independent health facility might provide, such as abortions or cataract surgery.

The obvious conclusion is that this government intends to limit the supply of medical services by restricting independent health facilities in locations it deems inappropriate, such as downtown Toronto, London, Windsor, Hamilton or Ottawa perhaps, even if there is a genuine demand for the services of the independent health facility in question.

Since the elderly are the beneficiaries of a disproportionate share of medical services, they stand to lose the most by this act. In any case, if limitation of health services is indeed the aim of this government, then surely all the people of this province should be apprised of this.

1440

The contention that this act is needed to ensure that procedures are performed in a safe, effective manner and to assure quality of care and standards belies the role that physicians and other professionals have traditionally had in self-regulation. Presently, the College of Physicians and Surgeons of Ontario is mandated to ensure the safety and effectiveness of medical practice and procedures and assure quality of care and standards. The college is soon to come under the influence of the health professions legislation review, and the Independent Health Facilities Act would only serve as one more mechanism by which the college could be made impotent.

With respect to the ministry's objective of regulating the delivery of services, I would again read "limiting" or "restricting" the delivery of services in place of "regulating." I, as a practitioner, might have to apply for an independent health facility superlicence, over and above my hard-earned licence to practise medicine, in order to provide services which the ministry determined fall within the purview of the Independent Health Facilities Act. Surely this new concept, requiring of trained, dedicated professionals a bizarre new superlicence, should be exposed as the unjust and illogical tactic that it is, geared only towards tight fiscal control and not at all towards enhancing the quality of care.

The ministry states that this act will not affect the provision of insured services in a doctor's routine office practice. However, it might be easily extended to restrict many so-called routine practices. All providers of services which entail a facility fee would be subject to the regulations of this act. There are numerous benefits presently paid by OHIP which are composed of a professional and a technical fee, the latter used to cover overhead. These include services as basic as an electrocardiogram or pulmonary function tests which are commonly performed as part of a doctor's routine office practice.

The ministry could arbitrarily reduce the technical component of any of these services to zero, making them unaffordable to the practitioner unless he applied for funding under the Independent Health Facilities Act. Such an application might be refused, thereby threatening somewhere in this province the ready availability of these basic services to the sick and elderly who most need them. Such individuals would be required to have these and other services performed at government-approved independent health facilities which might only be found at distant locations the ministry had deemed appropriate.

Many routine office practices might easily be forced into the independent health facility system despite the apparent assurance to the contrary in section 2 of the act. If other provincial governments have not been able to limit doctors' billing numbers, then surely this is the way this ministry will attempt to achieve much the same thing. Once again, there is clear evidence linking this bill with cost-cutting and restrictions on the provision of health care services to those who most need them.

The fact that the Minister of Health will be empowered to grant, deny or revoke a licence without appeal only serves to reinforce the unjustness of the thinking behind this act and the finality of the harm that will be caused to the health care system of Ontario.

Earlier irrefutable evidence of the real aims of this government and ministry appears to have been quickly swept under the carpet, perhaps only to resurface at a later date. I refer to subsection 34(1) of the original version of the Independent Health Facilities Act. That section proposed changing the definition within the Health Insurance Act of "insured services" from those services that are medically necessary to those services as are prescribed by the regulations. While I do not find this complementary amendment in the latest edition of Bill 147, I find most alarming the very idea that such a proposal could have been made.

With respect, the people of this province do not want bureaucrats determining what an appropriate medical service is, since the regulations might limit each of us to, say, no more than two electrocardiograms per year; no more than one ultrasound per pregnancy; no more than six blood-pressure measurements per year; or no more than 10 trips to the doctor, for whatever reason, per year. This might ultimately become no kidney dialysis for those over 65 years of age, as is presently the case in the United Kingdom, or no more than three consecutive days in hospital following an appendectomy, as is presently the case in many American health care plans.

This act might indeed have been drafted with the best of intentions, as the minister and her ministry contend; however, I find it hard to imagine that there was not some malice intended towards health care practitioners and gross insensitivity to the needs of the elderly and the sick. Regardless, the act itself is dangerous to the health and wellbeing of every citizen of this province.

The Chairman: Thank you for your presentation. We have a few minutes for questions.

Mr Carrothers: I want to go back to your comments at the top of page 2, the first full paragraph, because you seem to be outlining a purview of this act which is broader than I thought it had. I want to explore that with you.

It seems to me that this act is regulating the place in which a facility fee is charged. I think you have rightly outlined that some of the Ontario health insurance plan payments do indeed contain a professional or technical component. It is almost implicit within an OHIP fee that some amount of that is to go towards the cost of operating the office in which the practice is taking place. That is endemic. That is part of it.

You have outlined a number of things like electrocardiograms and so on. Is it common that a facility fee be charged for an electrocardiogram?

Dr Lipsitz: No, not a facility fee. What would be charged to OHIP for an electrocardiogram would be the professional fee on the one hand and the technical fee on the other.

Mr Carrothers: If I could stop you there, it seems to me that doing that is not contrary to this. This act gives no ability to control because it is the charging of the facility fee that triggers this act, if I am reading it correctly. Maybe I am not and that is what I am after.

Dr Lipsitz: If the minister and the ministry determine that the technical fee for doing an electrocardiogram should be reduced to zero, for whatever reason, it would no longer be feasible for most practitioners in their own office to do electrocardiograms. There would be nothing to cover the overhead portion of it. If they wished to continue doing electrocardiograms or any one of a number of other fairly common procedures, they would then have to charge a facility fee or something that would be interpreted to be a facility fee.

Mr Carrothers: Sure. You can postulate a whole number of events that are unlikely to occur and I would suggest that is one.

Dr Lipsitz: I would take much greater assurance, if I may, if there were something specifically in the act that addressed those issues, because at the moment it is very broad and very open-ended and there is nothing that suggests that this kind of thing would not happen.

Mr Carrothers: Maybe that is what I am exploring, because if you are outlining things that are commonly done, that I have had done to me in a doctor's office, I do not see this interfering with at all or even offering any possibility of control, because that facility fee is not normally charged.

I would agree with you that if the OHIP is cut to the point where you are not covering the office overhead, you have a problem but that is something completely separate from this. The whole system could be abolished tomorrow, too. We can postulate all kinds of things that are not going to happen.

You have suggested here that this can control the office practice and have then given examples, which I do not see being the case. That is why I am exploring them with you. Maybe I could just suggest to you that perhaps you are reading a broader purview to this act than is in fact the case.

Dr Lipsitz: There is nothing that restricts the act to only those things where a facility fee is now charged. It is certainly well within the power of the ministry, as it did recently, to impose certain changes on the OHIP schedule of benefits. The scenario that I put forward might indeed take place. If it is not with electrocardiograms, it might be with some other service.



There is nothing about this act that says if it is a service which was previously paid for by a combination of professional and technical fees, that somehow the technical fee will not be touched. The technical fee could be dropped to the point that, in effect, it would be converted into a facility fee which the practitioner would then have no choice but to pass on to the patient, thus bringing him into the purview of the Independent Health Facilities Act.

Mr Carrothers: I would suggest you are postulating a chain of events which I think highly unlikely. I do not see this act as being a threat to the operation of a normal medical practice.

Dr Lipsitz: With respect, I—

Mr Carrothers: Maybe we will agree to disagree on that.

The Chairman: I would like to get some time for a couple of more questions if we could.

Mr Jackson: On that point, it is my understanding that if a patient requires more service than OHIP currently covers, one way of paying for that is to charge a facility fee. Whether it is a medical procedure or not, you can call it a facility fee and they have access to it. This act would make it illegal to charge any such fee in that regard. I am not sure of your field of practice.

Dr Lipsitz: I am a general practitioner. In my own practice, there is nothing that falls under the category of facility fee.

Mr Jackson: I was not going to ask you that question anyway.

For example, the ministry can regulate, through its negotiations with the Ontario Medical Association, that which is covered and the number and frequency of certain procedures. Well-baby visits, I think you are entitled to two and I have never known what you are supposed to do if you need a third one. Who pays for it, since you are not supposed to charge us? What is your understanding of that?

Dr Lipsitz: I guess there are certain interpretations as to what a well-baby visit is. If you wanted to say that this is a minor assessment for which the charge is less, that is something which you can charge.

Mr Jackson: Okay. I guess there is an example. The example you are trying to illustrate that Mr Carrothers suggests really does not happen—and incidentally I would be very interested in having a look at Mr Carrothers's ultrasound, if he was familiar with all those treatments that were presented.

1450

Mr Carrothers: I think some confidentiality problems might arise on that, would they not?

Mr Jackson: I was just surprised that you were familiar with those procedures that have been done on yourself.

The Chairman: Are you relying on the chairman to secure that for you?



Mr Jackson: I just thought it was fascinating that he was familiar with having had an ultrasound done on himself, but anyway—

Mrs Cunningham: If you are a Liberal, anything could happen.

Mr Jackson: Anything could happen.

Mr Reville: I want you to know I am not going to look at it.

Mr Carrothers: Thank you, Mr Reville. I appreciate that.

Mr Jackson: I know your predecessor gave birth to several pieces of legislation.

It is possible in Ontario for a pharmacist to dispense a drug that costs him more money than he is compensated for under the Ontario Drug Benefit Formulary, the changes that were brought in by the government two and a half years ago. I can well foresee the point you are illustrating in terms of medical procedures, so I at least have embraced the notion you have tried to convey to this committee, while some members have not. I thank you for bringing that to the committee's attention.

I do agree that there are some very positive things in this bill, but it has within it the potential to control access as opposed to controlling cost, because it is very hard for us to separate the difference.

Dr Lipsitz: If I may make one brief clarification for Mr Carrothers, the idea of having technical fees reduced to zero and therefore incurring the wrath of the independent health facility system was a question which I raised at a conference organized by the Canadian Institute of Law and Medicine dealing specifically with this topic. At the time, I asked Dr MacMillan a question from the audience, trying to interpret for myself what the downside might be, as it were, the risks both for physicians and for patients.

I gave the example of an X-ray, which of course is not done in a routine office practice; it would be done in an X-ray facility. Right now the radiologist would be compensated for interpreting the X-ray and there would be a technical fee in addition to that to pay for the film, the cost of doing it, the salaries and so on and overhead.

I said, "In such a scenario, if you were a radiologist and would consider this to be your own private practice, could the ministry reduce the technical fee to zero and you would have to turn into an independent health facility and come under the scope of the Independent Health Facilities Act?" The answer was that that could indeed occur.

If I were a radiologist, I would say, "This is my private practice; this is what I do." Despite the assurance that this will not relate to a private practice, it would indeed appear to do exactly that, and by extension, I do not think the examples I have given are outlandish. I think they may well occur.

Mr Carrothers: I see a difference between the examples, but maybe we will again have to agree to disagree on this.

The Chairman: Dr Lipsitz, before we go to our next delegation, it might be useful to have Dr MacMillan comment on your last statement and perhaps clarify the point with respect to the different kinds of fees and what

is going on. The committee has had this before, but maybe we could have these briefly again.

Dr MacMillan: First, it is a rather expert analysis of the act. Read in that negative vein, I would say that what he has written is fairly accurate, but I think it has already been brought to your attention that it is certainly not the intention at all to move in negative ways but to move in a positive way.

The T fee could be reduced to zero. It would still be listed in the schedule of benefits; therefore, it would be extra-billing that would be charged to the patients, not a facility fee. If it were removed totally and we decided to take it out, then you are correct in your analysis, and my response is exactly the way you have said it today. But certainly if the government did that and took it out, then any charge to the patient would be a facility fee and they would have to be licensed. I am sure that is an accurate answer.

At any rate, the only other comment to make is that with regard to bureaucrats setting what this government is going to pay, they have done it ever since OHIP started. Maybe you are not aware of the process.

Dr Lipsitz: It makes people nervous.

Dr MacMillan: Your whole schedule of benefits is one that has been drawn up on the advice of the OMA; but decided whether they are reasonable charges and reasonable things to be covered, and then the recommendations to the minister and they are covered.

Dr Lipsitz: Just at that this critical juncture, though, is the one precedent we had had recently for the OMA not being consulted as to where the most recent increase would be distributed and how it would be apportioned among various sections within the OMA and various procedures. That worries physicians, and I think it will ultimately affect the way patients view what might result from all this.

The Chairman: Dr Lipsitz, I want to thank you on behalf of the committee for taking the time to come here today and share your views with us.

#### ONTARIO HOSPITAL ASSOCIATION

The Chairman: Our next delegation is the Ontario Hospital Association. Representing that organization Dr Dennis Tuck, chairman of the board, and—I understand there is a difference from the agenda; perhaps you could introduce the delegation.

Dr Tuck: I would be happy to do so.

The Chairman: We have allocated half an hour for your presentation; committee members would appreciate it if you would leave some of that time for questions from the committee.

Dr Tuck: I will do so. My name is Dennis Tuck. I am the chairman of the board of the Ontario Hospital Association. I am accompanied by two members of the professional staff of that association, Hilary Short and Colin Goodfellow. Unfortunately, our president, Gordon Cunningham, is on vacation; his vacation was arranged before this committee meeting was called. He would certainly be here were he in town.

As the brief points out, the Ontario Hospital Association represents some 225 public hospitals in the province plus over 100 other health care organizations. We provide service to those hospitals in two ways: first, as it were, internally, by helping them with the running of the hospitals; we help them in health and safety, labour negotiations, pharmacy and nursing advice. But we also have a very major function of public advocacy on behalf of the hospitals, and it is in that role that we appear here this afternoon.

If I might put my own position in context, I am a voluntary trustee on the board of the Metropolitan General Hospital in Windsor. I serve on the Ontario Hospital Association board as a representative of the southeast region and I am the chairman for this year. To put my other title in context, I should explain that I am professor of chemistry at the University of Windsor, not a physician.

As somebody who serves voluntarily on a hospital board, I can tell you that the aim of this bill is something which appeals very much to me. Our comments this afternoon are directed not towards the aim of the bill itself but towards some of the detailed mechanisms which we think are implicit in it.

The hospitals serve their communities, and anything that helps that service is something we will approve. Without doubt, if I were designing a health care service for a population of 7 million or 8 million people, I would include hospitals, independent health care facilities and individual physicians. The problem is that at the moment we have a system where only two of those components are in place, namely, the hospitals and the independent physicians. What is being inserted between these is the provision of independent health facilities; as I say, it is the proper thing to do, but in the actual easing into the system of these facilities, there may be certain problems. It is to those problems we have tried to address our brief. It tries to go into three different areas, and I will try to take those in succession and relate them to the recommendations which have been made to you.

First, we believe that hospitals are an integral part of the communities they serve and that under pressure—perhaps pressure applied by the ministry, pressure which I am happy to see is recognized in a carefully chosen quotation from the minister herself from last December: "In the last 10 years, day surgery, outpatient clinics and satellite operations have turned the face of the hospital towards the community." That, I believe, is a very accurate statement of where hospitals are.

One of the concerns we see in this bill is that the hospitals may be denied or in some way barred from fully taking part in the outpatient facilities and running those facilities, things for which they have taken some costs both in capital and personal charges to put in place. We are very anxious to make sure that in setting up the independent health facilities there is not a duplication of something which, in our view, hospitals have already tried to do and are competent to do further in the future.

1500

The set of recommendations, which I think I can address directly, are on pages 4 and 5 through to 11. We see the first point about the bill as being the need for the independent health facilities. We think those needs and the criteria which establish those needs should be defined as the result of a very comprehensive assessment, not only of the needs of the community but of the availability of the resources in that community and the impact an independent health facility might have upon an existing hospital; and the financial



considerations, which in our view are very important, because we do not want to see a system in which competing services are provided when the effect of the competition is not necessarily to the benefit of the consumer, and certainly not to the benefit of the taxpayer if the ultimate payment comes out of the same pocket, namely, the taxpayer's pocket.

So there is a set of recommendations under 1 which addresses that point. We say it should be a catchment area or a service area rather than just a locality which is specified, and that the proposal should include an evaluation of the cost-effectiveness against other methods of meeting the same need. In other words, we want the ministry to be sure that if it establishes an IHF within a given community, it has checked out not only that the hospital cannot do that but that the hospital cannot do it cheaper. These, I think, are important considerations for any taxpayer, or indeed any government, to put into place.

We are concerned about the criteria which might be applied in nonrenewal, or renewal for that matter. We say on page 6, under recommendation 4, that there should be a need to check whether the original proven need for the service might have declined. To the extent that these are matters to do with population growth, and therefore population decline, one should, I think, take note of the fact that in a changing population establishing a clinic for a certain purpose might prove to be useful in the short term but the need might disappear in the long term as the community ages. For example, a birthing clinic would surely have no place in a community where there were no women of childbearing age, as might happen.

We believe there should be frequent checks, and five years is the period which has been proposed. We would like to see that there is an automatic five-year consideration of the need to renew the licence. It should go beyond just the fact that nobody has complained. The ministry should take care that every five years the continuing need is established, presumably by the same sort of criteria which were in place when the IHF was first established. Again, we would like to make sure at that five-year interval that another health service or a public hospital cannot offer the same service as the IHF more effectively.

We as hospitals have been concerned that some of the services which we offer may be duplicated, as I have already said, and we are also concerned that the act specifically seems to deny to hospitals the right to apply for a licence for an IHF. To the extent that a satellite clinic operated by a hospital might be a very effective means of health care delivery, we would like to see that changed.

Those are some of the considerations we have about the establishment and the continuation, and the criteria which might be applied at that stage.

Our second set of concerns, and it really starts on page 8 of our brief, has to do with expenditures and quality assurance. We try to point out, on pages 8, 9 and 10, that part of the OHA's service to hospitals and, we believe, to the province has been to play a very major role in areas where costing has been at issue. We have spelled out some of the things we have tried to do.

One of the issues which constantly comes up when the Ontario Hospital Association meets in its annual convention is a motion from hospitals that are concerned about the competition they see in a number of treatment or diagnostic areas from private physicians. The problem goes something like



this, if I can use the example of X-ray diagnostic facilities as being typical: A hospital must run its X-ray and other other diagnostic facilities not from nine to five, five days a week, but every day of the week and every hour of the day in many cases, particularly if there is a large and active emergency ward. This means that the hospital has to provide both the equipment and the personnel for that 7-day-a-week operation.

There is nothing in the present act or in the proposed act which prevents a physician or a group of physicians from setting up competing diagnostic services, sometimes very close to the hospital, running those on a nine-to-five basis and on a limited range of services. Those physicians rightly charge OHIP for what they do. But in many cities one can find two or more services offering the same thing to the patient and really both drawing upon the same pocket, namely, the Ministry of Health, and ultimately the taxpayer.

We have spelled out some other examples where we believe this same sort of unfair competition or duplication is in place. We think this bill should be extended so that it considers the need for the establishment or continuance of those facilities, along with independent health facilities, in order that hospitals may be allowed and encouraged to do what they do best without feeling they are under unfair competition. Recommendation 8 really addresses the point I have just been speaking to.

We are also concerned, obviously, about operating costs. The essence of our proposal is in recommendation 7: that in licensing an IHF we would like to think the ministry will go for the global basis of funding rather than the fee for service. Again, it is the matter of duplication which is at issue. We realize we are all drawing from the same bag of money and we do not want that bag of money to run too empty too quickly.

Furthermore, in terms of capital costs for an IHF, there is a provision, as we read the bill, that in setting up an IHF the ministry may provide direct capital grants. As we have pointed out in our brief, this again runs counter to what is currently the practice in hospitals. If a hospital wishes to buy a new major piece of equipment, it has to find that money within its own total global operating budget; indeed, hospitals are required to set aside each year a sum of money which they carry forward as their capital equipment budget for the next financial year—sometimes with great difficulty, I can assure you, but they do try to do it.

The idea that somebody establishing an IHF could draw upon a fund which will provide, as I read it, both the building and the equipment in part to be covered seems to us to be unfair competition. To this extent, we would like to see the bill modified and we would put it, as we have in recommendation 9, that the capital costs be separated from the operating costs and not supported through facility fees; also, that in financing independent health facilities, the support should be no more than two thirds, as it is when a hospital wishes to expand its physical facilities.

We continue with another matter which is of concern in terms of how a hospital might be viewed against an IHF, and address the matter of quality assurance. Hospitals in Ontario, as we say, conform to rigorous quality assurance practices; on pages 14 and 15 we spell out just what some of these are. I can assure you that in particular the inspection program of the Canadian Council on Health Facilities Accreditation is a major procedure, one

which a large hospital will spend several weeks preparing for, and in some cases several weeks getting over.

There is nothing in the bill, as we read it, which requires similar prospective and retrospective review of an IHF. We would like to think that in modifying the bill some clause or clauses could be put in place to make sure that similar procedures are followed by IHFs as are followed by hospitals. It may be, and clearly I am not writing the legislation, there is some way in which the Canadian council can be made responsible or that hospitals themselves can take a role in this. As I say, it is not my job to say how it should be done, but we do believe very strongly, as we say in recommendation 11, that the bill should be amended to provide for the necessary and required participation of these facilities in quality assurance programs.

Finally, we turn to the matter of the integration of health services within a community, which I know is very much the thrust of the ministry. We think there should be more care taken in establishing an IHF and in continuing an IHF that it or they fit into the existing facilities of a given region or locality. The present licensing process would be centralized at the provincial level and we would like to urge that district health councils be given a strong role in reviewing the licence in the first place, and the renewal of that licence after a suitable interval.

As part of the council's recommendation for new and expanded programs, they would review the need for an independent health facility in their region. To put that into context, I should tell you that when a hospital proposes to expand into a new service or buy a major piece of equipment, it is required to appear before the district health council and properly explain why that hospital proposes to enter into a particular field of practice. They have to prove that it is not being done by somebody else already, in other words. We believe this is reasonable and that IHFs should be subjected to exactly that same test.

#### 1510

Furthermore, we propose in recommendation 13 that the "licences be required to detail proposed links with appropriate health and social services." It is very much the idea of a continuum of social services that we are addressing here. We would like to think that the patient who is treated in an IHF will have access to those same health and social services that he or she would have, had the person been a patient in hospital.

We are concerned that there is no provision in the bill for a community board structure. As I said at the outset of my presentation, the hospital is governed by a board of trustees comprised of local people who are volunteers and who serve to explain the community to the hospital as much as they explain the hospital to the community. We would like to think that there will be in place some similar structure, so that an IHF will also be responsible to its community in some way. I can accept that it would be unwieldy to have a board of trustees for every IHF. Nevertheless, I think some way of making sure the community input is recognized as important.

Finally, we are concerned, as we say in recommendation 15 that "IHF's which are independent of a hospital or a community public health agency be required in the proposal" to establish "formal links for case management purposes with either a hospital or community health agency." I suppose the real reason for this is the acceptance that every now and then the IHF will treat a patient where complications may ensue. It is clearly necessary for

there to be good links to a hospital, for example, so that a patient may be treated quickly without going through the admittance-through-emergency-ward style of procedure. In structuring the health care system within a community, we would like to think that the links between IHFs and hospitals or other health agencies would be considered.

I repeat that we believe the establishment of IHFs is a welcome addition to the battery of health care agencies within the province. We are concerned, as a hospital association, that hospitals not be damaged in the process and that we have a system in which hospitals can play what we believe is the very important role they have played and will continue to play in the future.

The Chairman: Thank you very much for a well presented and detailed analysis of the bill with your specific suggestions. We have time for questions and will begin with Mr Carrothers.

Mr Carrothers: I appreciate these as well. You have covered a number of areas. Your comments on diagnostic centres intrigued me. I may be reading something in here that is not there, but when you talk in terms of duplication of facilities and so on, am I taking you to imply that there may be too many of that type of facility in this province?

Dr Tuck: Yes.

Mr Carrothers: That was a very blunt answer. So you feel that we need to look at the numbers of those facilities that are in the province and bring them under control?

Dr Tuck: Very much so.

Mr Carrothers: You are suggesting they be brought under the control of this bill?

Dr Tuck: This seems an ideal agency for doing it, on the face of it, yes.

Mr Carrothers: I was not reading too much into your comments then. As for questions of quality assurance, you have made a number of comments about making sure there is quality assurance. It is intriguing because we have had so many witnesses come before us talking about this bill and almost implying there is going to be too much. It is an interesting alternative perspective. This seems a fairly elaborate system and maybe this is a question for the ministry. There is an accreditation board that deals with hospitals, is there not?

Dr Tuck: There is a Canadian accreditation body for all and it now goes beyond hospitals. It was originally the Canadian Council on Hospital Accreditation. It is a little broader now. It talks of health facilities.

Mr Carrothers: Would it be the kind of accreditation body you think might—

Dr Tuck: It could be if it has the facilities and personnel to do it. I understand there is some question about whether they do indeed have the number of people to do the job, but certainly, in principle, I would say yes, it is the sort of body that should do it.

Mr Carrothers: I wonder, Mr Chairman, could the ministry tell us



briefly if it has had any discussions with that group about this?

Dr MacMillan: We have had discussions at length with the Canadian Council on Health Facilities Accreditation. The very fact that they changed their name was that it was becoming recognized in Canada that the quality control that was necessary in hospitals could not be excused in the rest of the community and there was a need and indeed, an increasing demand on the part of that association to get involved in other facilities.

So Ambrose Hearn, the former Deputy Minister of Health from Newfoundland, who is now the executive director, welcomed our contact. We have met with him in Ottawa and Toronto. They have, in fact, prepared a proposal to be considered by the ministry and we are engaging in negotiations with them for a very formal proposal on how they would be involved and their involvement would be on a voluntary basis, as it is in hospitals, for the many reasons you know. That would be in regulations in this act when the regulations are written.

Dr Tuck: I am pleased to hear that.

Mr Carrothers: I suppose this is something of interest to you. Maybe this group could speak to us, but let us talk about that later, Mr Chairman. I do not know if there is much more time. I have two more areas I would like to question. You made a comment on capital costs and that they would be removed, and if I am understanding your recommendation, that a facility applying for funding only get operating funding and that they somehow have to come up with the capital on their own hook, or am I overstating your recommendation?

Dr Tuck: I suppose that would be the farthest we could push it, yes.

Mr Carrothers: I am wondering, based on many of the examples we have had of groups that could apply and make use of this, it would seem the thrust would be that this legislation is intending to take the health system, if they might be community-based groups and nonprofit groups which might not have the ability to do that. I am wondering how you would see a group that is community-based getting capital, or why you would want to see them cut out from this in that fashion.

Dr Tuck: It sounds a little harsh, I know, but if I can use a phrase from another political argument, we want everybody to be playing on a level playing field.

Mr Carrothers: You can apply under this, can you not? Can the hospitals not apply under this and get that same—

Dr Tuck: The original act, as it was written, specifically excluded hospitals from applying.

Mr Carrothers: I may have interrupted your question, I am sorry.

Dr Tuck: No, that is okay.

The Chairman: The minister suggests there might be a need for clarification on that point.

Dr Tuck: Yes, I would be happy to have that clarification.

Hon Mrs Caplan: The policy decision which I have stated to other



deputants who have come before the committee is that the hospitals would be able to apply under section 4 of the Public Hospitals Act. The determination can be determined in a number of ways. They can also, through setting up another entity—as you know, hospitals do either join with a community group in a joint venture, or as an individual entity—be able to participate in the request for proposal.

This was taken because of the experience hospitals have had in the area of quality assurance and because we wanted the opportunity for joint venture and participation in the linkages, which are often so important.

Dr MacMillan: That is complete.

Dr Tuck: Let me just say I am very pleased to hear that statement, that we did not understand that. I am glad to hear it. I have no doubt a large number of hospitals will wish to play a community role in that sense. But to come back to your point: as I say, the provision of money for equipment within hospitals is something that hospitals are required to find within their own total global budgets. There is not a line-by-line capital item budget provision. Whether there should be is another matter, but there is not.

So on this level playing field approach, we were concerned that it seemed that independent health facilities were being given an edge to which hospitals could not—

Mr Carrothers: And that maybe they are going to get—

Dr Tuck: This seems to be, perhaps in light of what has been said, a bit redundant, so I will perhaps leave it at that.

Hon Mrs Caplan: There is one point which I would like to state, if I could, without rousing my colleague. There is the intention not to disadvantage community groups, which often tell us they feel the hospitals have resources which are not available to them. So the opportunities within this, I think, are very important, that we not disadvantage community-based organizations. That is why, when we approach this, what might be a level playing field to one may be seen as a disadvantage to others.

1520

Mr Jackson: There seems to be an interesting evolution occurring here with respect to how hospitals were originally treated by the visionaries and the draftpersons of this bill and now where we have come to. So, I have some concerns in this area. I have a hospital in my community that has an IHF associated with it. It is sort of a day-hospital clinic at the other end of our city and it works extremely well. However, all the human resources' protections that are applied to the nurses in a hospital also apply to the same nurses who operate within the independent health facility.

I have asked the question of the minister. I wonder what your understanding is, having read the legislation, if, as a hospital, you developed one, two or three IHFs? Would the legislation, in your view, require you to provide all the labour protection for those nursing staff? Or would it free you from any collective bargaining responsibilities? You could basically start fresh and anew. The emphasis here, of course, is on health care delivery, not in terms of personnel.

Mrs Short: I do not believe hospitals would consider that their

employees in the independent health facilities would be treated any differently from the employees in the hospitals.

Mr Tuck: Agreed.

Mr Jackson: So that is your gut feeling?

Mr Tuck: Yes.

Mr Jackson: I am asking you: In your reading of the bill, what sense of that are you getting? Is it silent? Can you direct me to a section of it?

Mr Tuck: I think it is silent on that particular issue, but I have no doubt, as Mrs Short said, that that is exactly how hospitals—

Mr Jackson: Your association would have no difficulty embracing amendments to this bill which clearly indicate that where a hospital undertakes an IHF, all bargaining and all labour protections would transfer for it.

I want to make it clear that I am not talking about surplus and redundancy matters. I understand that aspect and that is a separate part of the concept of providing equally good, safe and efficient health care but for less cost: namely, less personnel. So I am not talking about surplus and redundancy; I am talking about the normal rights and privileges that nursing staff, and others, enjoy in a hospital environment with respect to other elements of working conditions.

I foresee an opportunity where large numbers of workers in this province would be denied access to normal grievance and bargaining procedures. Now this is not an issue in a self-contained independent health facility that is separate and distinct from the hospital. So your association would have no difficulty with the legislation which entrenches the noncontract-stripping of employees who transfer as a result of an IHF?

Mr Tuck: Given that we have not seen the text of the law you are going to write, in principle I would say that we would not have any difficulty with the approach that you have outlined.

Mr Jackson: My second question has to deal with this area of a hospital's ability to raise funds in the community under the separate arm of the Charitable Institutions Act or whichever one it is which allows you to have an attractive charitable number and the ability to give tax receipts. It strikes that hospitals across this province have millions of dollars. My hospital has \$14 million sitting in a bank account waiting to be spent.

Mr Tuck: Your hospital has everybody else's envy, in that case.

Mr Jackson: Yes; we are very proud of our hospital and we are very proud of the community that helped build it. However, we are anxious to get on with some community-based programs. Now obviously, no for-profit or nonprofit IHF could compete with a hospital proposal because at the hospital's fingertips are access to those funds since the hospital would only really be changing the location and some of the procedural matters in order to reduce the cost; in order to get the approval of the minister. Do you have any thoughts on that?

Since you have addressed the issue of the unequal playing-field between

the nonprofit, I propose to you that, in fact, the hospitals present an uneven playing field because you have access to bank accounts currently in existence and, in the case of the difference between a nonprofit and for-profit IHF, one will have access to charitable receipts and foundation funding of their own, whereas a for-profit would not be able to pass itself off and obtain a federal charitable exemption. Do you understand the nature of my question?

Dr Tuck: I understand the nature of the argument.

Let me of course say—perhaps I should not, but I will say it. There must be very few hospitals in this province that could boast of the amount of money in their foundation funds that you are speaking of. The only ones I would know of would be those that have collected that money with the intent of building a new hospital building and for one reason or another have not been able to get on with that.

Mr Jackson: Your association, more than any in this province, would be keenly aware of the election announcements of hospital beds. The recent Premier's Council on Health Strategy statement clearly indicates that more beds are not necessarily in the best interest. Therefore, there are many hospitals that have been told, informally or formally, that those bed allocations may not be forthcoming and that community-based programs will be the order of the day in the alternative.

Therefore those hospitals—and there are many, I suspect, whether their bank accounts are in eight figures or four figures—still have a considerable amount of money to apply to the community-based programs. It will not go into beds, but it can now go into clinics.

Dr Tuck: Yes.

Mr Jackson: I am not trying to disagree with you, but my understanding is that we are talking about a considerable number of hospitals that now know they are not going to get the full political pronouncement of beds.

Dr Tuck: Let me try to divorce the answer from any argument about how many beds might or might not be wanted. If a hospital has the funds to establish an IHF and if it can make the underpinning of its presentation to the ministry on those funds, then it seems to me that would be, in principle, a proper use of the funds which have been raised from the community. It would serve the community by providing health facilities. To that extent, in principle, I can see no objection to that. If you are saying that gives the hospital an unfair advantage—

Mr Jackson: You introduced the concept of unfairness. I just posed an alternative way of looking at it from where I sit, having no particular axe to grind or point to put.

I wish we could go further. I want to say this is an excellent brief. You have really caused us to focus on several matters. I was intrigued by your point that when need is reduced to a point, that it return back to the hospital. That speaks volumes in terms of a perception that perhaps maybe the hospital service should be phased out and the clinic might go to a 24-hour basis.

Dr Tuck: Oh, indeed.

Mr Jackson: I just found that concept fascinating on page 6. It also implies that we could reduce the number of services rendered in hospitals to a point and then begin to control more directly the access points in clinics. There are many points you have raised and I appreciate it. It will take me quite a while to go through your brief.

The Chairman: Thank you. Two other members of the committee, possibly three, have requested further comment. I will go to Mr Reville first, and then the ministry has a point of clarification on how hospitals are going to be applying. Dr MacMillan has a comment.

Mr Reville: I very much enjoyed your brief, both in its content and its presentation. In fact, some of the arguments are expressed with such felicity in the written text that it seems a shame they are not on the record.

I just want to pick out a line that impressed me a great deal. On page 21, following a Spasoff quote, it says, "The Independent Health Facilities Act encourages a concentration of physicians and technology in what could be called high-tech, high-volume health care boutiques."

It then goes on to describe how developing a smorgasbord approach to health services delivery—that would be independent practitioners, large institutions and high-tech, high-volume health care boutiques—would create further dislocation for the patient. Basically, disorientation is the concern, I think. You then recommend a mechanism whereby you hope you might prevent the loss of patient self-management, in recommendation 15.

I too criticize this bill because I see basically hospital X or baby hospitals appearing around doing the same sorts of stuff that are currently being provided in hospitals and in doctors' offices, perhaps at less cost, perhaps not. One wonders what that has to do with empowering a health care consumer. I cannot see that it has anything to do with it. But you suggest that links have to be established with a hospital or a community health agency so you can do case management. How would that work?

1530

Dr Tuck: I am glad you liked those phrases.

Mr Reville: I liked them a lot. I will probably use them often, actually.

Dr Tuck: The sort of example we talked of when we were discussing this matter might concern a birthing clinic. The patient who develops complications at a late stage must then be transferred to the main hospital structure. It is important that structures be in place to allow that to take place easily. Equally, for the patient who might have developed, in another area, complications which would allow him or her to go home but nevertheless with clear evidence of the need for continuing care, there have to be mechanisms in place to make sure that, for example, home nursing or home care of some sort can be provided.

That might not be, almost certainly would not be within the main structure of the IHF. After all, nobody is going to set up a whole smorgasbord of services around an IHF, to keep on using that phrase. The thrust of that recommendation is to make sure the structure is in place on a broader base than just the IHF itself would represent. We want these facilities to be tied into the main health care within a community.



Mr Reville: I understand what you say and I can see why they would be necessary in those examples that you use. I am not sure how that increases consumer self-management particularly. If a family were to decide that it wanted its child to be delivered in a birthing centre, then clearly one of the things it would want to know is, if complications do result and it needed to relocate to a hospital—they would want to know that anyway. Let us suppose I am contemplating some cataract surgery. How do I make a decision whether to go to the Park Plaza and have it done there or go to the Wellesley Hospital and have it done there? I cannot imagine really that the Park Plaza operation is going to be able to develop the kind of links you are talking about in an environment as busy as Metropolitan Toronto.

Dr Tuck: I think that is just the issue we are addressing. We want to make sure the patient who has received treatment through an IHF is not just cut off once the treatment is over but is still part of a continuum of health care as he or she would be had he or she been at a hospital for this procedure. The hospital follow-up, we hope, is good. We want to make sure that the IHF follow-up is good, whether the IHF itself does it or somebody else.

Mr Reville: Let's suppose I did go to—I had better not use that particular hotel because I do not want to embarrass anybody. Let's suppose I got my eye surgery done at an independent health facility and then I present at one of your hospitals two days later with something horrible, some haemorrhaging going on inside my head or something, and I then become unconscious. How are you going to know what happened to me in the first place?

Dr Tuck: That is precisely the point we are addressing. We want to make sure somebody has thought about this before it happens and has thought about the procedures which might be in place for the transfer of records or information.

Mr Jackson: Your place is particularly suited for that. You have placement co-ordinator services and relatively new services within your hospital which would lend themselves to that continuum and that linkage. An IHF does not have that infrastructure or access to those resources. You can flip between your IHF and your hospital, which would work very well, actually.

Dr Tuck: Yes, but we want to make sure that flipping process, as you call it, is a smooth one which does not cause problems for the patient.

The Chairman: Mr Reville, we have a couple of supplementaries on that last point that you raised.

Mr Reville: Yes, carry on.

Mrs E. J. Smith: I find this most amazing, because the one thing this bill is doing seems to be the thing that we are talking about here. I completely agree with you that linkages are very important and would have to be very carefully worked out.

The Chairman: Will you ask your supplementary?

Mrs E. J. Smith: I will ask the question.

The Chairman: I did have people ahead of you on the list, so a quick supplementary to this, please.

Mrs E. J. Smith: Sorry. It is supplementary to that. Hypothetical

cases are being brought up, but we did have the doctor here who does surgery and uses the hospital. In fact, he pointed out that there is no control on quality now. He is a quality doctor and told us that he has good quality and pointed out to us that without this bill there is no control on his quality. In fact, this bill will assure for him and other such practitioners that there be quality. Do you not see it that way? Do you see it differently? He felt that some people like himself were doing operations just as individual doctors without quality control and indeed should be brought into this bill, as he will be, with quality control.

Mrs Short: I think we would argue it is probably an improvement over what there is now, but there probably could be more quality assurance built in. There should be more formal and perhaps external quality assurance built in also, in addition to what is currently in.

Mrs E. J. Smith: Maybe you could have some suggestions on more quality control, but I think the whole bill is directed towards quality control.

The Chairman: Mr Carrothers, on this point as well.

Mr Carrothers: I want to pick up specifically on Mr Reville's example.

I would like to know the difference between having what David just outlined, the surgery being done at an independent facility and then something else happening and his going to the emergency at his local hospital. What would be the difference in terms of a continuum of care? If I had that done at Wellesley Hospital and then went home to Oakville and had a problem and walked into my local Oakville hospital and passed out exactly the way he has described, there is no continuum there either, is there?

Maybe the continuum comes from your general practitioner kind of knowing where you are going and being that linkage, but the fact that it is done at an independent facility versus a hospital does not seem to make a difference to me.

Mr Goodfellow: That may be correct, but you would be introducing greater numbers of places where the accountability does not exist.

The Chairman: Mr Reville, I had recognized you and these were supplementaries, so back you you.

Mr Reville: Did the sign help you recognize me? I am done, thank you very much.

The Chairman: I have Mrs Cunningham on the list. The ministry has a clarification on how hospitals apply. We will go with that and then to you.

Hon Mrs Caplan: There was a question raised on how hospitals would be able to participate in a request for proposal for an independent health facility. I told you what the policy is. I would like to ask Gil to let you know how the act will read, just so there are no surprises.

Mr Sharpe: I have heard some discussions that sounded to me as if you thought that hospitals as hospitals will now be able to apply for licences under this act. That is not the intention. Although hospitals have been taken out of the exemption in section 2, so has everything else. We simply wanted to

transfer that into regulations, for reasons I expressed last week. We have such a growing list of exemptions that are going to have to go into the regulations that we have decided to put everything into the regulations rather than having a few in the act, and hospitals are included. It is simply a matter of moving hospitals from section 2 into the regulations.

My understanding of the reasons behind this was, first, that hospitals have their own process under the Public Hospitals Act, in section 4, to apply for ministry approval to extend their operations, to get additional funding for community programs and so on. To provide this mechanism to them would have two mechanisms, whereas the most appropriate one is through the Public Hospitals Act. If a hospital is recognized through the district health council as the most appropriate route to provide the service, then the DHC would not even identify the need for an independent health facility or the need for a proposal call. It would simply recommend that the hospital be given that.

The other thing is that, again, it is my understanding from discussions some time ago with the Ontario Hospital Association that there may be some charges made within hospitals, direct charges to patients for things that could be seen as adjunctive to the provision of the insured hospital service, and it would be inappropriate to catch hospitals within the ambit and the prohibitions within this statute. Again, it was important that the act not apply to hospitals.

I just want to make it clear that it is our intention simply to move the hospitals from the exemption in the statute to an exemption in the regulations, which we are developing. It is almost complete and, as promised, we hope to have it before the committee prior to clause-by-clause so that the committee will be able to see the proposed list of exemptions.

1540

Hon Mrs Caplan: In my response, I did mention section 4 of the Public Hospitals Act and also the opportunity for hospitals to set up corporate structures to be able to enter into joint venture. The questioning of my colleague took you down another road, and I did not want there to be any misunderstanding.

Dr Tuck: Yes. Thank you.

Mr Jackson: Mr Chairman, I am not going to debate; I just wanted to ask a question for clarification.

The Chairman: Sure. Yes. Absolutely.

Mr Jackson: I did not catch all that legalese but are we able to have a hospital open up an independent health facility, yes or no?

Mr Sharpe: No.

Mr Jackson: The answer is no. Now you know you cannot operate an IHF. You came to the table assuming that you could.

Mr Sharpe: No.

Mr Jackson: No. You always knew you were ineligible.

Dr Tuck: Perhaps I can tell you what I think at the moment. My

reading of the bill before today was that hospitals were prohibited from applying under this bill for an independent health facility.

Mr Jackson: Right.

Dr Tuck: I now know that to be correct. But as I also understand, in the Public Hospitals Act there are ways in which a hospital can apply for something which will look like, sound like and behave like an IHF but will not be under the Independent Health Facilities Act. I see you nodding so I presume that is correct.

Mr Jackson: You control completely those applications as opposed to the IHF applications which are prescreened through the district health council.

Hon Mrs Caplan: There are two ways that hospitals can participate. I am going to ask Gil again to try to make sure that is clearly understood because in fact it is a legal application and the policy intention is to permit hospitals to be able to respond to requests for proposals through other vehicles.

Mr Jackson: I am satisfied with that answer.

Dr Tuck: The two vehicles, simply put, would be, as I have said, the Public Hospitals Act, which is the most direct and clear way to do it. If, for some reason, a request for proposal goes out for an independent health facility and the hospital wants to get involved as a public hospital corporation, it could not apply; but it may be possible, for example, through its foundation to apply and respond to the proposal call through a separate corporate entity.

Dr Tuck: I think the thing that caught the hospital's attention in this was the feeling that there was a funding mechanism available for the IHF which was denied to hospitals and to the extent that funding for an IHF, which is put up through the Public Hospitals Act, would be perhaps a debatable matter within the ministry. That, I think, is perhaps where the distinction lies between the two procedures; but perhaps this not the place to—

The Chairman: We are well over the time allocated, and I did have Mrs Cunningham waiting patiently. We went through several points of clarification and interjections, so I will take you before we dismiss this delegation.

Mrs Cunningham: I was getting rather excited there for a moment because I thought we might all be on a level playing field and somebody in the ministry might have identified a need and everybody could apply to provide the service, people working together through district health councils, and that maybe the public would benefit because the most cost-efficient service would be provided. I could see hospitals providing services in remote parts of their communities because they would set up a very small independent health facility, but I do not think the playing field is the same, given the capital differences that you brought to our attention.

If it is different, and you can get the answer to that question, good luck to you, because from what you have said today and from what I got from the ministry, you are talking about two thirds capital cost. That is all you can get from the government, I think, around anything you do. Is that correct?

Dr Tuck: I believe so.



Mrs Cunningham: We are not sure, although we have been trying to find out, just how a nonprofit group can get the capital funding; but I would guess it would be 100 per cent under the other act, so all of a sudden we have got two competing groups. Maybe your ability to raise the capital or already have the capital is greater than the other, but to me that does not look like people working together; so I am disappointed. You might respond to that.

Dr Tuck: I think unless the system which has been put in place addresses the needs of the community and unless it provides good health care, then we are all wasting our time whether we are involved in hospital, IHFs or anything else. To the extent that there is a local input, which we hope will be put in place, at any rate, whereby the district health councils can comment on proposals or calls for proposals, we think that is the local input which is needed. I think that is a critical part of it.

I would not like to see the negotiations for an IHF carried out between a group in a city remote from Toronto and the ministry officials without there being some comment and interpretation on needs from a local body independent of both.

Mrs Cunningham: I am trying to go back to the beginning, because we have been through so much, and in all fairness, the ministry has tried to answer the questions fairly and some of them have been very difficult, but if we go back to the very beginning and take a look at the intent of the act, which is written on the inside here, it says:

"The bill would authorize the establishment and operation of independent health facilities. Under the bill, the Minister of Health will decide upon the need for such a facility and will call for proposals."

The criticism from the public--

The Chairman: Are you going to bring your question to a conclusion?

Mrs Cunningham: Hopefully. I have been very patient and I think this is a critical point.

The Chairman: There are also other delegations waiting patiently too. I am conscious of that as chairman.

Mrs Cunningham: I know. You have a very difficult task and you are doing a wonderful job and I shall try to be succinct.

The point is that if the minister is calling for proposals, and that is written in the bill, and if the ministry is deciding exactly, or the director will select the proposal and the director will be empowered to suspend or revoke or refuse, clearly the power for all of this is with the government.

The district health councils have been mentioned often, but they are not in the act. You are quite right. Most of us got the good information we have on the district health councils from another document, which I think was called a fact sheet. Most of us felt very comfortable with it, but the bottom line is in your concerns, and that is that I think somebody is going to have to look at a very integrated approach for calling for proposals where the real need comes, from the community.

I think already district health councils have told the government what services are missing in their communities, and I am now looking at the more

broad-based terminology that you use when you talk about patient catchment areas or service areas as opposed to localities. I commend you for this and I guess my final question is: Do you feel any more comfortable or have any of the positions you have taken in this brief been changed as a result of what we have said today? We will be quoting this brief, obviously. It is a very strong one.

Dr Tuck: Have any of our positions been changed? No, I do not believe the positions have been changed. I think we have been reassured by some of the answers which have been given. Although the district health councils are indeed only mentioned in the fact document that was put out, I would hope they will be actively involved and I hope that when the bill is rewritten the bill will call for them to comment to the ministry on proposals which are made.

Mrs Cunningham: That has been most helpful. Thank you.

The Chairman: Thank you very much for coming to the committee today and presenting the brief and answering all of the questions.

Dr Tuck: Thank you very much for your tolerance.

Mr Jackson: While the next deputant is preparing himself, could I just ask a question to counsel to respond back at a later date? Mr Sharpe indicated that hospital foundations could apply for an independent health facility as a separate entity. I was intrigued by that response and I would like him to include in his response back to me on my legal questions in this regard the extent to which that legislation permits them to operate an independent facility, and second, the degree to which the minister would be capable of also having access to hospital foundation funds as a potential capital source for any IHF proposal, whether it be nonprofit, profit or a modified hospital board or hospital foundation. I think we better be clear that the hospital board and the hospital foundation are two relative but separate entities.

The Chairman: Can I just leave that as a request?

Mr Jackson: Yes, I just want it put on as a request.

The Chairman: Dr H. Brown is our next presenter. My apologies, Dr Brown, for being somewhat behind schedule, but I have found myself waiting in doctors' offices as well. It happens in many forums.

Please be seated and welcome to the committee. We have given you approximately 15 minutes.

HARRY BROWN

Dr Brown: Just as a rebuttal to your comment, my greatest pleasure is to sit in a barber's waiting room and wait to be served. It is the only time I have to relax and to take my time and reflect on various things.

I would like to thank the chairman and the committee for having me here today and listening to my concerns as an individual. I am a general practitioner and an individual who has been concerned with health care in the province all my professional life and even beforehand.

If you will bear with me for a few minutes, I would like to read a

statement, if I can read my own handwriting, and you know physicians have difficulty reading their own handwriting.

1550

As I see it, the purpose of Bill 147, known as the Independent Health Facilities Act, was to enable physicians to establish clinics outside of hospitals where specialized procedures could be performed. The objective seemed to me twofold: (1) to expand the availability of services to the general public, obviating long waiting lists and delays in hospital; and (2), by reimbursing the physician for a technical component or an overhead expense for these procedures, to save the difference in costs in performing the same procedures in a more costly hospital setting. As physicians, we would still be reimbursed by the OHIP fee, whether the procedure was to be performed in hospital or in an IHF, therefore providing some method of cost saving to be obtained.

In giving structure to the act, we see a number of obvious consequences. By definition, an IHF is any place other than a hospital where insured OHIP services are performed. This all-encompassing definition might include a wide variety of functions not yet included. Presumably the definition could be used by government to designate all or any general medical clinics or any or all private doctors' offices where procedures are performed. Outside the hospital setting, these physicians would therefore be required to obtain special licences under the act designating their place of practice as an IHF in order to work in the offices which they now practise in or when setting up an office in a different location.

One could foresee a system in Ontario where physicians who are granted a general licence to practise on the basis of fitness and training by the College of Physicians and Surgeons of Ontario would also, in order to set up a practice, require and seek a licence as an IHF from an appointed director of the Independent Health Facilities Act, granted or denied as he sees fit. The unsuccessful candidate, though fully qualified by education and training, would be unable to practise in his or her location of choice or even in any location in the province.

He could of course resort to a delayed costly hearing or lawsuit in order to seek such a licence. By the time the hearings were finished, he would be at considerable expense. The denying of a licence or the revoking of an existing IHF licence in an already established practice would ruin the professional life of those physicians denied.

The licensing requirements could be used by government as a very effective method of rationing medical care by limiting the number of medical offices and locations and limiting the numbers of physicians entering or remaining in practice, this controlled by government through an appointed director of the Independent Health Facilities Act.

In British Columbia they twice attempted to deny billing numbers to newly graduated doctors who wanted to set up their practice in locations of their choice, restricting access of newly qualified physicians to the practice of medicine in certain areas and providing a method of rationing medical care by restricting the physician pool in these particular areas. What is worse is that the citizens in those particular areas were also denied access to physicians with new knowledge and new expertise on the basis of doctor population alone and not on the basis of need.



In Ontario it might be the Independent Health Facilities Act that is used to limit the number of independent health facilities and therefore the number of physicians in practice, rationing health care to the people of Ontario.

The government vehemently denies that the act will ever be exercised to include private doctors' offices; yet the act, by definition, could permit this to happen. If indeed the government is sincere, it would be easy enough to amend the definition of the IHF to apply only to specialized particular services covered by OHIP, and not to allow any ambiguity or doubt as to the government's intention.

Perhaps we gain true insight into the Ontario government's intention in section 33, which offers the government arbitrary power to change by regulation, make an absolute mockery of the act as it stands, and take absolute control over rationing of health care services without cause. For example, it is able to reclassify the definition of a health facility. It can define health services and, by regulation, change the entire meaning of the act and composition of what health facilities are.

This section gives arbitrary powers to government, which can be used to restrict the availability of any or all health care services outside of hospitals. This type of regulatory power is an affront to patients' rights in the province by providing an arbitrary means of rationing health care and access to medical services.

The director appointed to administer the act can grant licences at will; no conditions are set out for granting or denial of licences. Licences are reissued every five years, so the public is assured of services for a five-year period of time only and no longer. If a physician has a licence to operate an independent health facility, develops procedures, trains staffs and passes knowledge and expertise to younger physicians who may join him in the service of his community by his own experience, he may not benefit from the good works he has done.

He can develop no equity. If he dies, his heirs will inherit nothing. No provisions are made in this act for the development of great clinics like Mayo, Cleveland or institutes like the Montreal Hospital and Neurological Institute. Every five years the continuity of the institution will be in jeopardy of survival. Why should legislators be entitled to a pension for two consecutive terms in office? Why should business people be allowed to be rewarded by way of equity in the sale of their business, and physicians not? What manner of discrimination is this? What type of incentive is this to expand and better health services?

The greatest affront in this act, however, lies in sections 25 and 26, where an inspector appointed by the minister can enter without a warrant to ensure that the regulations of the act are followed. Also, section 25 permits an assessor to collect samples of substances from premises and allows that assessor to gain access to information with respect to patient records and records of other sorts.

These changes are a direct affront to the civil rights of the people of this province, both doctors and patients, and contravene section 8 of the Charter of Rights and Freedoms, as well as permitting confidential health information to be divulged to civil servants or politicians without permission of the patient and without just protection of the confidentiality of this personal information.



This piece of legislation acts as a licensing process that is arbitrary, and the licences are arbitrary, and mitigates against expansion of needed facilities and services outside of hospital. This government has given itself arbitrary powers to change the nature and scope of the act by regulation, without consulting the people by debating issues of substance and gaining approval of Parliament.

A costly bureaucratic structure is to be set up with the power to license not on the basis of medical necessity but at the will of the appointed director. Quality control of work done in the independent health facilities is a costly duplication of services to the taxpayer, as it is already being done in all facets of medical practice by the College of Physicians and Surgeons of Ontario.

As a citizen of Ontario, I demand protection of confidentiality of my personal health records and consider it an invasion of my privacy and civil rights. It is inconceivable of any government to suggest, let alone allow, search and seizure of records without warrant. Again, I guess from the legal point of view, the case of *Hunter v Southam* in 1984 is the case that probably will be called in question if this is ever questioned in the Supreme Court.

In conclusion, let me say that this act is sufficiently flawed and dangerous to warrant its withdrawal. Should it be amended, I would recommend that the definition of "independent health facility" be sufficiently narrow with regard to scope that it can never be used to ration health care by lessening the number of facilities or physicians. Facilities should arise on the basis of medical need, not on the basis of political or economic expediency.

Creation of a licensing vehicle or mechanism is a restrictive process, and therefore obstructive in the expansion of provision of service. No money or agency need be funded or created to monitor quality of care, as the College of Physicians and Surgeons, which is empowered to protect the public by law, has the facilities and expertise to do so. Government should not have the arbitrary regulatory powers that would change the nature and scope of a health care facility without the consent of the people through Parliament.

No government should advocate search and seizure without just cause, as defined by an objective third party when obtaining a warrant. In any law pertaining to patients' personal medical records, maximal safeguards should be made to protect the privacy and confidentiality of these records.

If this government were interested in expanding the availability of services outside of hospitals, all it would have to do is offer physicians overhead fees to defray their expenses. The desire on the part of physicians to serve their patients and the increasing medical need would be sufficient to accomplish this task.

I would like to thank you for the opportunity of speaking on behalf of myself, as a physician and as a private citizen.

The Chairman: Dr Brown, I want to thank you for coming before the committee and sharing your views with us. Your brief will be helpful for the committee later when it does clause-by-clause. Your time has been used for the presentation of the brief, so I thank you for coming.

Dr Brown: Thank you.

The Chairman: Our next delegation is the College of Physicians and Surgeons of Ontario; Dr Brian H. Dingle, president, and Dr Michael E. Dixon, registrar. Welcome to the committee. My apologies for being a little behind schedule. We have allocated half an hour for your presentation, and hopefully there will be some time for questions as well.

#### COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Dr Dingle: I am Brian Dingle. I am a practising oncologist in Kitchener and currently the president of the College of Physicians and Surgeons of Ontario. To my right is Dr Michael Dixon, who is the registrar of the College of Physicians and Surgeons of Ontario.

You have before you, I believe, the submission on bill 147 from our organization.

The college's mandate: As you know, under the Health Disciplines Act, the role of the college includes the following: (a) to establish, maintain and develop standards of knowledge and skill among its members; and (b) to establish, maintain and develop standards of qualification and practice for the practice of medicine.

The college, therefore, has a statutory obligation to be intimately involved in the development of standards for the medical profession. As you know, this is a key component of the proposed Independent Health Facilities Act. The college welcomes this opportunity and looks forward to working with independent health facilities in this extremely important task of assessing the quality of the care provided to the people of Ontario. In fact, the college is already involved in assessing quality of care of physicians' practices in several areas.

Our comments and suggestions: We believe people must be able to trust the quality of care they receive in independent health facilities, just as they do in hospitals and doctors' offices. The key is to set standards for care in these facilities and then closely monitor them to make sure these standards are met.

There have been concerns expressed by some presenters about cost cutting through competition for licences. That possibility makes it imperative that standards and processes be in place to prevent the quality of care in these facilities from being compromised by cost considerations.

The college is pleased to be part of this process and will encourage and stimulate the development of meaningful standards and measures of quality assessment in these facilities. In carrying out quality assessments it is very likely that from time to time the college will detect a physician or physicians with questionable or reduced knowledge or clinical skills. We have mechanisms in place now for dealing with such a situation.

Normally such cases are referred to the registrar of the college for an investigation under section 64 of the Health Disciplines Act. This is, for the most part, a review of a physician's paper records. However, over the past few years we have come to believe that section 64 referrals are not always the best way to pinpoint a physician's strengths and weaknesses in actual practice. The college feels that the public would be better served if physicians with problems in the areas of knowledge or clinical skills were further examined not by an assessment of their medical records but rather by a more thorough, in-depth look at the doctor's skills, judgement and knowledge, which would lead to a clear understanding of his or her educational needs.

As a result of two years of planning and development, such a process exists today through the physician review program established by the college at McMaster University. The program takes doctors through a two-day, in-depth evaluation involving oral and written tests, visits with simulated patients and discussions of the doctor's own charts and records. Through this evaluation, the doctor's strengths and weaknesses are pinpointed and an educational program is then developed to address any problems.

The college believes in the need to assess the quality of the care provided to patients in these diagnostic or treatment facilities. In supporting this important goal, however, we wonder why similar concerns are not directed towards facilities providing uninsured services, for example, cosmetic surgery clinics, liposuction clinics or other locations providing services not covered by OHIP. There would appear to be a similar need to assess the quality of care in these circumstances, and the college believes that this possibility should be pursued.

Finally, there is another portion of this legislation which deals with the review of doctors' billing in unlicensed facilities. With regard to the concern expressed by other presenters over the absence of warrants in this situation, the college does not believe that warrants are the right way to deal with these investigations. It has always been the practice of the college to give notice prior to an inspection and to inform the doctor involved about the nature of the inspection. In that way, the doctor is not taken by surprise.

This co-operative approach to investigating doctors' practices has always worked well, and we believe it is a better, fairer approach than obtaining warrants, which would give the college the right to search doctors' offices and seize records with no prior notice or explanation whatsoever. Using warrants is more in keeping with police investigations than professional reviews. The proposed legislation requires that prior notice of an inspection be given to doctors by the college and we support that provision.

In summary, the College of Physicians and Surgeons believes this legislation will help ensure that quality of care is a key consideration in expanding health care resources in our communities. We are committed to developing quality assessment programs for independent health facilities that will protect the high standard of medical care patients in Ontario have come to expect.

1610

**Mr Carrothers:** I am intrigued by the prep program. I want to go back to that. We have had a lot of discussion these last few days about what seems to be called quality control. This was a very intriguing proposal, which I take it you are proposing to institute but have not yet done. You start off your paragraph talking in terms of physicians with problems in areas of knowledge, etc, and they would go through this program.

Do you only find out or is your only contact with physicians to see if they are having trouble with their practice after a complaint, or do you have or propose to have any sort of, for want of a better term, spot-check system where you might randomly visit offices, on notice perhaps, but just to see what is going on and getting an idea of how that practice is being carried on? Do you do that sort of thing now or are you proposing to?



Dr Dingle: First, if I could correct one statement you have made, we are currently using the prep program in limited situations.

With respect to ongoing monitoring of doctors' offices, there are many different ways in which we do that currently. To explain that, we have a peer assessment program that randomly selects doctors in different targeted areas of concern that we have. We have the complaints, of which you are aware, that come to the college. We also have coroners' inquests which are reviewed by a committee of the college. We have mechanisms for obtaining or at least delivering information to the registrar through private members of the college, physicians and other people who are concerned about activities.

On the one hand, yes, you need to have some kind of complaint with respect to a doctor, but there are many different ways by which that concern can reach our offices.

Mr Carrothers: You say you have a program of visiting randomly. How many doctors would be visited in a year? What sort of staff would you have to do that?

Dr Dixon: At the present time, we are visiting 400 physicians a year. We anticipate that we will be able to increase that number. But even so, by targeting groups of physicians we think are at higher risk, we identify a significant number of physicians each year who require some degree of counselling or remedial education to upgrade their skills. Those we are particularly concerned about we refer to the McMaster program, which has been referred to, for a more in-depth assessment of their clinical deficiencies so that a remedial program of education can be designed and carried out at one of the health science centres. Currently we have reviewed 48 physicians at the McMaster program.

Mr Carrothers: How many doctors would there be practising in the province right now?

Dr Dixon: In the province there are approximately 18,000 doctors practising. This program, I should add, though, is directed mostly at physicians in office practice. There are other mechanisms for institutional practice. This program was introduced almost 10 years ago for office-based practice. So it is primarily directed at primary care physicians and primary specialists.

Mr Carrothers: So they do get involved in other areas. I guess what I am leading to is that in my own profession, the legal one, the Law Society of Upper Canada seems to have set up a program where it attempts to visit every lawyer at least once in his career. That seems to be the goal. I know they visited me. Is that the sort of objective you might ultimately be seeing? Four hundred seems awfully low when you have that many doctors in practice. Would you want to expand that program at all?

Dr Dixon: We certainly will. We have expanded it already. It is a matter of developing the assessment technology. The visits themselves have gone through some evolution. They take approximately half a day. They involve one or two peer physicians who attend at the doctor's office, which is preceded by a previsit questionnaire. The physician himself is interviewed, his medical records are reviewed by the peers and other information about his practice is obtained. We hope to develop better ways of being more efficient and therefore being able to visit more physicians in a year.



Mrs Cunningham: Given the objectives of your professional organization and your concerns with regard to quality of assessment, you did not discuss in any detail in your brief sections 25 and 26 of Bill 147. I am just wondering if you have any comments to make about it, given that other physicians have come forth and are very much concerned about the intrusiveness in the processes in sections 25 and 26 which have to do with assessment and inspection.

Dr Dixon: We have had ongoing discussions over the last six or eight months with ministry officials, and the college is very satisfied with the provisions that have been developed in the bill that is before us with respect to the college's responsibilities.

We made reference in our submission to the inspections that would be carried out in unlicensed facilities, in other words doctors' offices, to look for any billing irregularities. We have mentioned that we do not believe warrants are necessary in this regard. We do a number of other inspections of doctors' offices for reviewing billing problems and we do not have and never have had the need for warrants. We have never had any concerns expressed by the physicians in that regard. We always give notice. It is done with the agreement of the physician in terms of the time. If the physician thinks there is no basis for the inspection, he of course can take legal remedies to prevent the college from undertaking the inspection and we will defer until that has been resolved by the courts.

Mrs Cunningham: I guess I can only say that given the standards and what you have just said, the processes in this bill are different and physicians will be working in licensed facilities; there is no doubt. Tests, records and whatnot will be looked at whenever the government feels like looking at them. They have brought to the attention of this committee their concern about processes as well as patient confidentiality.

You were saying that in your professional role, the College of Physicians and Surgeons of Ontario, you are not concerned about those processes as written in this bill.

Dr Dixon: We think that the assessment of the quality of medical care, wherever it is rendered, falls under the statutory mandate of the college. Therefore, it is appropriate that the college be able to assess the quality of care in independent health facilities, as it is to a limited extent in public hospitals. It has the same right to obtain information from medical records in public hospitals. So we think it is quite compatible. Since the whole thrust of this bill is to really address the evolution of the delivery of medical care, which was previously confined primarily to public hospitals, we think it is quite appropriate.

Dr Dingle: If I could add too, we are concerned about confidentiality. We believe, however, that it is well covered here.

Mrs Cunningham: Many of your colleagues do not share your view.

Dr Dingle: We deal with this kind of concern under many different jurisdictions at the college and it may be that we are more familiar with it.

Mr Reville: Do you have any idea of how much your involvement in this legislation will cost and what kind of establishment you will require to carry out your duties under the legislation?

Dr Dixon: We have attempted to make some preliminary estimates and we have obtained from ministry officials their best estimate of the number and types of facilities that will be licensed in the first year or two of operation of the bill.

It is very difficult to project the costs. There are two types of costs. There are the initial startup costs of establishing standards for different types of facilities and then there are the ongoing costs of inspections and review of the inspections. Part of the difficulty is that the frequency of inspection is entirely within the discretion of the director. He triggers the process as to whether he wants the college to do an assessment and he has the option of negotiating with the licensee, so the college may not in all cases be the assessor. It is very hard for us to estimate. We have done some initial work in terms of developing standards, which we do not think is going to be terribly expensive. We hope to enter into some formal discussions with the ministry soon.

1620

Mr Reville: When you have concluded the process of estimating that, I assume you anticipate that the Ministry of Health will defray the costs thereof.

Dr Dixon: We will be looking to the ministry to share costs.

Mr Reville: Would that be purchase of service or a shared-cost arrangement?

Dr Dixon: We will be looking, as I say, to share the cost. We think that some of this responsibility, the establishment of standards, clearly rests with the profession, but I think in this particular situation we may need some seed funding. We have also had discussions with the Department of National Health and Welfare with respect to the development of standards on a national basis. We may have some access to support from that sector.

Ms Hosek: I find your approach to this act truly reassuring on the questions both of confidentiality and the approach you want to take to looking at quality assurance. The question I ask is not completely connected to this act but is sparked by what you said in your presentation earlier, and that is I wonder whether you have, in the work you currently do, a method for looking out for any impairments in physicians having to do with their own personal difficulties.

We hear about physicians, like other people, suffering from various forms of addiction and other kinds of problems. When you do the spot-checking that you do, is that one of the things you routinely look for and is that one of the things you think of expanding as you talk to both the federal government and ourselves about checking and seeing how health care is going to be delivered in the province?

Dr Dingle: Certainly, concerns about physicians, as I indicated earlier, come to us by many different routes. We are aware of the potential and possibility for physicians to be impaired by virtue of drugs, alcohol or physical ailments. We do have the ability to investigate that and submit the physician, for example, to a fitness-to-practise hearing, as opposed to the more unfriendly and somewhat hostile discipline hearing, in order to deal with

it, perhaps to direct the physician towards rehabilitative programs that we co-operate with.

I should say that in the rehabilitative programs that we co-operate with we do have a certain level of confidentiality there. If they are referred there without going through the college, we do not know about those cases, but certainly those who are referred to us we have full reports on.

Dr Dixon: I might just add, further to those comments, that for some years the college, in co-operation with the Ontario Medical Association, has had a Doctors on Chemicals program which is a professional program to address the needs of physicians who have impairments of one form or another. We attempt to deal in a collegial manner with the physicians to ensure that, first of all, they get into the necessary treatment programs they need, and second, that their professional practice is not put at risk and patients are not put at risk. We do have the legislative authority to take formal action if needed. In most cases, fortunately, we are able to gain compliance with the physician because we approach it in a nonpunitive, rehabilitative mode rather than trying to simply lift the licence of the physician.

Ms Hosek: The way one has to deal with any member of the community, obviously.

Dr Dixon: I hope so.

The Chairman: I have a question that is also in line with the confidentiality issue. It seems to me that some of the groups that expressed concerns most strongly were the psychiatrists and psychoanalysts who appeared before the committee. Do they come under your area of review? Do they come under your responsibility?

Dr Dixon: Psychiatrists and psychoanalysts who are physicians come under our jurisdiction, yes.

The Chairman: And in your experience, have you had any particular problems with respect to any reviews in those areas, particularly on this point of confidentiality of records?

Dr Dixon: Actually, the psychoanalysts particularly have been concerned, for obvious reasons. We have entered into discussions with them in the past with respect to our peer review program and indicated that we had no interest in having any access to the identity of their patients. We simply wanted to have access through our physician inspectors to their records to ensure ourselves that they were meeting the standards of practice they should be meeting. We were very much in agreement and worked out a scheme with them that they could go into some system of putting their select files into blank folders and label them with some identifier that they themselves knew so that we would have no means of identifying the patient. We would simply see the actual case record.

This is a scheme that may have greater applicability in the future in other areas. It is an increasingly sensitive issue. It is simply a mechanical problem in terms of our inspections, because in doctors' offices, of course, their medical records have patients' names on them and they are difficult to put into some code form on a random basis.

But we are certainly, as a principle, not interested in the identity of patients unless we are following up a referral from the health insurance plan,



where of course the actual patient's identity has to be given to us so that we can match up the clinical record in the doctor's office with the claim that was made by the doctor.

The Chairman: Do you seek approval of the patients in that particular instance?

Dr Dixon: No, we do not.

The Chairman: I believe the minister had one point of clarification.

Hon Mrs Caplan: There was actually one question that was raised regarding the ministry and my level of concern around procedures being conducted in facilities where those are uninsured services. I would like to just respond to you.

From our conversations, both formal and informal, I think you know that my primary concern is quality assurance. I believe generally that we have good quality care in the province that we can improve greatly in our quality assurance techniques to give everyone in this province the comfort that we are doing everything we can in an environment of constantly trying to improve.

You raise an issue regarding diagnostic as well as uninsured services, and I would like to say that I share your concern and would be willing to work with you to determine what appropriate mechanisms could be put in place so that we could have quality assurance in those environments as well.

The Chairman: Do you have any concluding comments you wish to make before you leave the committee?

Dr Dixon: Perhaps only to emphasize that the thrust of our interest in this bill is the quality assessment components. We recognize that other aspects of the bill are controversial and raise concerns with our professional colleagues, but from the perspective of the college, we are very supportive of the proposals to involve the college in the quality assessment. We think this is very appropriate and we have made a solid commitment to do that and are in the process of developing the necessary mechanisms within the college to meet those needs.

The Chairman: Thank you for taking the time to come here today and give us the benefit of your opinions and professional advice on this.

Our last presentation today is from the Coronation Health Centre. Representing that organization we have Bonnie Assad, manager. Welcome to the committee. We have allocated 15 minutes for your presentation and you may use all of that for the presentation. However, as you have probably seen in observing, committee members appreciate an opportunity to ask questions.

#### CORONATION HEALTH CENTRE

Mrs Assad: Thank you for this opportunity to present our ideas as well. I represent Coronation Health Centre and I would like to present to the standing committee on social development a brief outlining what we have been doing at Coronation Health Centre to date. In addition, I would like to propose what we envision doing once Bill 147, the Independent Health Facilities Act, is in place.



Approximately 18 months ago, the Coronation Health Centre was formed by a group of 20 Cambridge physicians for the following purposes: (1) to prevent a commercial walk-in clinic from moving into our community; (2) to give a sign-out service and more or less permanent locum service to a group of general practitioners in our community; and (3) to provide an operating room facility in order that minor procedures such as laser surgery, possibly cataracts, dilation and curettages, etc. could be performed without having to rely entirely on our local hospital facilities.

### 1630

It was our intention to purchase a laser and charge the patients a \$75 facility fee. However, subsequent to that time, the government announced the Independent Health Facilities Act, or Bill 147, and we then put our plans on hold in regard to the operating facility until we could work out and understand the details of Bill 147.

In the interim, we have continued to very successfully operate Coronation Health Centre on Coronation Boulevard in Cambridge.

A number of our local physicians, as well as the initial participating group, utilize Coronation Health Centre as an overflow service to their offices and also as a sign-out service for nights and weekends. Occasionally, some of the members of the various call groups will actually come in and work at the Coronation Health Centre and see their patients in that locale, as opposed to seeing them in the emergency room at the hospital.

Prior to the establishment of Coronation Health Centre, several of the physicians would sign out directly to the emergency room of Cambridge Memorial Hospital when they were taking off an afternoon or an evening. Many of those physicians now utilize Coronation Health Centre for a similar purpose. It was the intent of the original board of directors to be able to return not only the notes of the patient visit but also some financial return to the individual physician investors who wished to avail themselves of the services offered at Coronation Health Centre.

Much to our surprise, many other physicians in the community, who are not investors, have continued to support Coronation Health Centre as well by sending their patients to the facility on either nights, weekends or afternoons that they choose to take off and, in fact, we have had some physicians sign out entirely to Coronation Health Centre while they are on vacation, while having made alternative arrangements to have their in-hospital patients seen by various consultants.

Due to the shortage of physicians in Cambridge, which arises from a multiplicity of factors including (1) a rapid population growth; (2) physician attrition through death, retirement, etc.; (3) changing work patterns in regard to physicians being more lifestyles orientated; and (4) a decline in the desire to work undesirable hours such as nights and weekends, Coronation Health Centre has evolved into a multifaceted clinic.

We do indeed see walk-in patients directly off the street. In addition, however, we see a large number of patients who are sent from both the participating and nonparticipating physicians who are either overbooked or choose to sign out for an afternoon or evening. In addition, we have begun to develop a service for the various industries in our community. We are able to provide EKGs, audiometry services, laboratory testing and physical examinations under one roof and are therefore able to conform to the standards

that many industries require. We also provide urgent care for minor injuries occurring in the various industrial workplaces such as removal of foreign bodies from the eye, suturing and minor burns. Changing patient patterns, such as working mothers and shift work, also make the attendance at Coronation Health Centre without an appointment very desirable.

We still hope to do minor surgical procedures and, in fact, some dentists in our community have approached us with a view to doing dental procedures in the operating room as they seem to have difficulty in getting access to the operating room at the local hospital.

Peter Fraser from the Ontario Medical Association did address us on the whole issue of independent health facilities and in fact came to Cambridge to advise us prior to this facility being established. He is aware of the operating procedures we wish to establish and intends to endorse such clinics that are physician-run and -sponsored.

When patients are seen in our facility, a duplicate copy of their records are circulated daily to their family physicians, regardless of whether they are investors or not. Patients are specifically instructed to return to their family doctor for follow-up care. We prefer that their sutures be removed or any additional follow-up care be done by their own family doctors. This is distinctly different from commercial walk-in clinics which tend to encourage their patients to come for repeat visits.

We firmly believe that Coronation Health Centre is distinctly different from a commercial walk-in clinic, as we are equipped to do a wider array of services and have significant physician input, co-operation and utilization of their own clinic; and we still hope to do minor surgery.

It is our firm opinion that we would be able to provide a more cost-effective environment for minor procedures without compromising the quality and time factor of health care.

First, it would be possible to utilize trained paramedical assistants in place of registered nurses to a greater extent than might be found in a hospital setting. We would be able to simplify the instrumentation and draping for many of these procedures. As these procedures would not be competing with major procedures in the operating room of our community hospital where invariable emergencies such as motor vehicle accidents, appendectomies and caesarean sections lead to delays, the time structuring could therefore be much more rigid, thus avoiding expensive after-hour utilization of hospital facilities and personnel.

Currently, our local hospital is unable to provide funding for the ongoing operation of a laser, even though several physicians have offered to provide capital funds for the purchase of this instrument. We are of the opinion that a private group of physicians could provide modern technology in such a facility, particularly if it were allowed to bill a facility fee or tray fee to help defray the cost of such technology.

Patients have indicated that they would be prepared to pay such fees if it would facilitate their having procedures done in their own community or avoiding lengthy hospital waiting lists. Therefore it is our hope to do minor surgical procedures within the Coronation Health Centre once the legislation is clarified.

In conclusion, it is our belief that the concept of the Coronation

Health Centre could well serve as a model for similar future facilities in other communities in our province.

The Chairman: We have some time for questions from committee members.

Mrs Assad: I will do my best.

Mr Matrundola: I would like to congratulate you for the fine presentation, and looking at the photographs here, I believe it is an excellent facility.

How many doctors do you have there on duty?

Mrs Assad: We have 20 physician investors. We have approximately 12 physicians that we call upon to work shifts, two of which each work almost 40 hours per week; but the others are people who will come in and work maybe one shift a week, maybe one a month.

Mr Matrundola: These are doctors who also work at the hospital across the road, I suppose?

Mrs Assad: Some of them are the physicians who are investors. We draw on McMaster University, where there are a lot of physicians doing their post-graduate work; they like to earn a little extra pin money and so they will come in and work one shift at a time for us.

Mr Matrundola: How is it funded?

Mrs Assad: The initial investors put in \$2,000 apiece, took out bank loans and leased their equipment on a lease-to-purchase.

Mr Matrundola: How are the doctors paid? Through OHIP?

Mrs Assad: We are paid through OHIP and have a salary for the physicians who come in and work a shift.

1640

Mr Matrundola: Also, you mention in your brochure here that you accept Visa or Mastercard.

Mrs Assad: Yes.

Mr Matrundola: Can you give me an example of when people would use Visa or Mastercard if they already have OHIP?

Mrs Assad: Someone coming from out of country.

Mr Matrundola: Oh, so out of the country and so forth.

Mrs Assad: Yes.

Mr Matrundola: I see.

Mrs Assad: Or someone who just does not have OHIP. On some occasions people have come in, they have not had OHIP, they have given us their Visa and then we tell them how to apply for an OHIP number. Once they have done that, they come back to us and once we are paid by OHIP we refund them the amount

that they paid us.

Mr Matrondola: I see. Very well. Thank you very much.

The Chairman: Thank you very much for your presentation and for taking the time to come here today to share your views with us.

Mrs Assad: Thank you very much.

The Chairman: Members of the committee, that concludes the list.

Mr Carrothers: I wonder if we could bring something up. A bit earlier on we discovered there is a group, the health facilities accreditation—I forget the name.

Dr MacMillan: The Canadian Council on Health Facilities Accreditation.

Mr Carrothers: The Canadian Council on Health Facilities Accreditation. That sounds like a good name. It appears to have a possible role here and I wonder if we might explore the possibility of having it come to speak to us if we have some time on Tuesday. They might be able to add some interesting and valuable information. I wonder if we could ask the clerk to look into that.

The Chairman: First of all, I would like to report that the clerk has scheduled Mr Linden for 10 o'clock Tuesday morning and we estimate that his time and whatever time the committee members wish to use for questions, would probably be about half an hour; maybe a little longer. If you will recall, we had originally thought we might need some of the time for Mrs Mauro, but she has already been here.

However, we have also received an offer from someone who has been an observer at some of the hearings, Louise Demers, who is executive director of the Waterloo Region District Health Council, who observed some of the hearings, heard some of the questions by committee members and noted that there was no one from any health council in the province before us. She offered to come Monday or Tuesday before the committee to answer any questions we might have of someone representing a health council.

Mr Carrothers: Perhaps both of these groups would be prepared to come in.

The Chairman: I am just pointing that out as additional information and I am seeking direction from the committee. You will recall that we had cut off the number of presentations at the beginning of the hearings. However, the committee itself may initiate requests to groups if it so wishes. What is the response?

Also, the clerk pointed out to me that Mr Hearn of the Canadian Council on Health Facilities Accreditation was on our original list very early on and when the clerk's office phoned to book their time, they declined.

Mr Carrothers: They did?

The Chairman: Yes. If the committee requested them they probably would—



Mr Carrothers: We have been talking a great deal about accreditation and quality control. It appears they are going to have a role. I would certainly find it interesting to hear what they have to say, and perhaps the district health council as well because we have discussed a great deal about them. That person is correct; we do not have anyone. Since we are here Tuesday anyway, we might look into those issues. It would help us understand it. I would certainly be for it. Do I need to move a motion, or how do we work this?

The Chairman: Any reaction over here?

Mr Reville: I'm sorry; what do you want to do on Tuesday?

The Chairman: We wanted to add to the one item we had.

Mr Reville: And that—is it possible to amend it?

The Chairman: Yes, for half an hour.

Mr Reville: That is in the morning or the afternoon?

The Chairman: The morning. We are meeting only in the morning Tuesday. To add the Canadian Council on Health Facilities Accreditation and possibly Louise Demers, executive director of the Waterloo Region District Health Council.

Mrs E. J. Smith: What do we have on Monday?

The Chairman: On Monday we have a full schedule in the afternoon. We are starting in the afternoon. We usually do, on Mondays, to give people travel time.

Mr Reville: By all means.

The Chairman: Is that acceptable? The clerk will contact those two organizations and see if they are able to come.

Mr Carrothers: Sure. We can invite them. If they cannot come, they cannot come.

The Chairman: Ms Demers indicated Monday, but Monday is quite full. It is difficult to fit her in on Monday.

Mr Reville: We are starting at 1:30 pm on Monday?

The Chairman: Yes, 1:30 on Monday.

We also have Alison's report, which will be tabled with us on Tuesday morning.

Mr Reville: Well done.

The Chairman: I understand we are in here on Monday afternoon and Tuesday morning, in this room. The meeting is adjourned until 1:30 pm on Monday. Note the change from 2 pm.

The committee adjourned at 1646.

Lacking nos. 17-18



CARON  
XC12  
-578.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT  
INDEPENDENT HEALTH FACILITIES ACT, 1989  
MONDAY 28 AUGUST 1989





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Eves, Ernie L. (Parry Sound PC) for Mr Jackson

LeBourdais, Linda (Etobicoke West L) for Mr Daigeler

McClelland, Carman (Brampton North L) for Mr Beer

Reville, David (Riverdale NDP) for Mr Allen

Clerk: Decker, Todd

Staff:

Drummond, Alison, Research Officer, Legislative Research Service

Spakowski, Mark, Legislative Counsel

Tucker, Sidney, Deputy Senior Legislative Counsel

Witnesses:

From the Ministry of Health:

Spence, James M., Special Counsel to the Ministry of Health; with Tory, Tory,  
DesLauriers and Binnington

Sharpe, Gilbert, Director, Legal Services Branch

Keyes, Kenneth A., Parliamentary Assistant to the Minister of Health (Kingston  
and The Islands L)

MacMillan, Dr Robert, Executive Director, Health Insurance Division

Erratum: In the list of witnesses for issue S-17, Rebecca Gotlieb should have  
appeared as Counsel, Legal Services Branch, Ministry of Health.

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 28 August 1989

The committee met at 1429 in committee room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: We received Alison Drummond's report and summary, which was circulated to all committee members late Tuesday, just before we adjourned. I thought it would be appropriate simply to indicate to the committee that you have an opportunity at this point to ask Alison any questions, because Tuesday you had not had a chance to read it. If there is anything in her report that you wish to query or seek additional information on, Alison is here to be of assistance to the committee.

I raise the point for another reason and that is, if there is nothing, Alison has other work she could be doing, and she could be called back whenever needed if the committee feels it is not necessary to have her around during part of our proceedings.

Mr Reville: Just before we adjourned last Tuesday, Alison did say there was an updated appearance list coming. Is that what you said, Alison?

Ms Drummond: It was about the exhibit numbers. I did not have a complete list of the exhibit numbers but Todd does, if any members of the committee want it.

Mr Reville: Mr Decker, were you going to provide that list to us? Thank you. I do not have any other questions.

The Chairman: Do any committee members have questions to Ms Drummond? Is there agreement then that Ms Drummond could retire from the committee and be available at a few moments' notice if we need her later?

Mr Carrothers: How many moments' notice?

Ms Drummond: A couple of minutes.

Mrs O'Neill: I certainly think there is agreement.

I would like to say again, and I have already expressed this privately, but I really did find it, on a solid read of this, to be an excellent report of a very difficult subject and very succinctly placed and I think the characteristics of each brief were brought forward with a great deal of skill.

The Chairman: I think your sentiments express the feelings of the committee as a whole. Thank you very much, Alison. Let me echo those comments on behalf of the committee.

We now have the copies of the Progressive Conservative amendments and they are distributed to the committee.

Mrs O'Neill: Are there more than the three or four that seemed to be out of place when we came in?

Mr Decker: Just four of them.

Mrs O'Neill: Four more?

Mr Decker: No, four in total.

Mrs O'Neill: I had them at my place.

Mr Eves: If I may clarify, we have four proposed amendments to section 1, which have been distributed now. Hopefully, within a matter of minutes, the rest of the amendments that we propose will be arriving. There is going to be one proposed to section 8, three to section 9, one to section 10, possibly one to section 17, depending what happens to the one to section 10, one to section 18—

Mr R. F. Johnston: Two to section 21.

Mr Eves: And two to section 21, as my colleague Mr Johnston says. I do not think we will get past section 21 today, but if we do, I will be happy to come up with the rest.

The Chairman: Thank you for letting us know so we know what the lie of the land is here.

Mr Reville: On that same point, I have tabled three amendments now, one today and two on 10 August. There may well be other amendments coming. That depends somewhat on what the government amendments we have just received say and somewhat on some conversations I am having with the ministry later.

I would suggest that the way we could deal with the difficulty of not knowing what all the amendments are is to agree that a section can be reopened if an amendment comes forward. If the section does not need to be reopened, it does not get reopened. That is one way to do it. The other way to do it would be to have a discussion on an amendment and stand down the vote or to stand down the whole section until all the material is available. That confusing array of options is available to us.

The Chairman: Thank you for your assistance.

Mr Carrothers: When would you likely know whether you are going to be making amendments to more sections? Would you know by tomorrow?

Mr Reville: That is difficult to say.

Mrs O'Neill: He is trying to confuse us, I know.

Mr Reville: No, actually I am trying to be of assistance.

The Chairman: I gathered that.

Mr Reville: It would be useful, obviously, if we knew precisely what the contours of the landscape are or were going to be, but we do not. It will save time in the long run if we just try to be flexible at this stage, because depending on the outcome of the discussions I will be having with the ministry and that the committee will be having, it may not be necessary to move some

amendments and we can save a whole bunch of grief. If, on the other hand, those conversations have a different outcome, then there will be a lot of grief and a lot of amendments. I just wanted to share that with you.

Mr R. F. Johnston: Maybe even committee of the whole House.

The Chairman: I would like to seek the direction of the committee, whether you would like to begin today by starting right in on clause-by-clause or would you like an opportunity for some general comments from each party before we go into clause-by-clause?

Mr R. F. Johnston: There are two things. We can deal with this because you have called it, but I do think we should make the decision on how to proceed on Mr Reville's difficulty. I have a suggestion on that.

Mr Reville: What difficulty?

Mr R. F. Johnston: In terms of whether or not—

Mr Reville: My difficulty is being dealt with by a different committee. The standing committee on government agencies is doing it.

Ms Poole: First you have to understand the difficulty, and therein lies the problem.

Mr R. F. Johnston: Therein lies the rub, all right.

I was going to suggest that yes, it would be appropriate to have some general discussion before you move into specific clause-by-clause.

On the other matter, I would suggest the easiest thing to do is not to take the final vote on any section today but to take votes on specific amendments as they are brought forward. We could always then go back to any individual section with another amendment, if that should come because of the discussions with the ministry or whatever following.

The Chairman: The other alternative, other than the ones that Mr Reville mentioned, would be at some point to allow for some caucusing so each party could study each other's amendments.

Mr R. F. Johnston: We do that anyway. I am just suggesting at the moment that, rather than requiring a reopening motion, which is more difficult to get sometimes, it would be easier just not to take the vote on each section as we proceed with the amendments which we have before us at this point.

The Chairman: Okay.

Mr Eves: I have a problem with either of those suggestions, but I think it probably would be helpful—I know it certainly would be helpful to me and I presume to every committee member—if we could have some brief opening comments by each caucus, and as well I would like to hear from the ministry, because it may be proposing some amendments that maybe alleviate some of my concerns. If we could have a general discussion about that, I think it might save us a lot of time in the long run.

The Chairman: Mr Carrothers, your comments in reaction to the suggestions?



Mr Carrothers: Perhaps we could agree not to take any final votes today and see where we sit tomorrow in terms of doing it, taking final votes on the sections we discuss today.

The Chairman: Okay.

Mr Carrothers: We could just defer them until tomorrow anyway and perhaps Mr Reville will be in a better position.

The Chairman: Mr Reville, does that satisfy your request?

Mr Reville: What I think will work most effectively for the committee is to do what Mr Johnston and Mr Eves suggest, just to begin by having some opening remarks. In that connection, I would like to make some remarks and I would like my colleague Mr Johnston to make some remarks about the women's issues aspect of it. I know he would be brief. Then I am sure Mr Eves would like to make some remarks on behalf of the Progressive Conservatives.

It would also be useful, I think, to have a quick review of what the government amendments are going to be. That may well alleviate some of the concerns that I have and perhaps Mr Eves has.

To go to the practical administrative matter, I think it is wise to start going clause-by-clause, keep the votes open until it is clear that there are not going to be any amendments, and then we can do a whole raft of them at once and that will solve the problem. Rather than saying we will keep them open today, it might well be that it would also be useful to keep them open tomorrow as well.

My suggestion is that we can certainly debate sections, we can move amendments and deal with amendments such as are available, but we should not close off a section until such time as it is clear that the section has no more inputs coming.

Mr R. F. Johnston: Stack them.

Mr Reville: We will just stack them. My recommendation is that we stack each of the sections until it is possible to deal with them all.

Mr Carrothers: My only concern is that I would like to move through. That is why I was wondering if perhaps by tomorrow we would have a sense of that.

Mr Reville: I am not sure that we will.

Mr Carrothers: So I wanted just to leave it until then.

Mr Reville: We might be to the last word and not have to go back at all, which would be fine.

The Chairman: I am told by Mr Keyes that the ministry is prepared to brief the committee on the amendments that were tabled today. Briefings were given on the previously tabled amendments. I think that is a good way to begin.

Mr Carrothers: Before we do that, though, just to make sure that we know the context we are dealing in, perhaps I could suggest that we have been working from this reprinted version of the bill and I believe all the amendments have been drafted on that basis, so perhaps I could move that the

committee take this as the bill for working purposes and that we deem all of the amendments in this to have been moved. When we discuss new amendments, we will know that they are amendments to this document and not to the bill as it was at second reading. That would make things pretty clear and hopefully avoid confusion somewhere down the road.

Mr Reville: Mr Eves will speak for himself. Normally, opposition parties would spend several days discussing this approach of deeming amendments to have been put and we cannot let this go by without noting that 30 amendments are indicated in this reprinted version. We have had another amendment tabled earlier in the proceedings, plus 13 more today, for a total of 44 amendments.

As I have said before, you would think the government would have its work done before it appeared with the bill. In this case, that seems not to have been the case, although the government might say in its defence that the 13 recent amendments are a result of the trenchant and cogent arguments that have been put by deputations and members of the committee and I am sure they will say that because that is what governments always say. All that said, I have no objection.

1440

Mr Eves: Maybe I should just put ditto marks. I have to be careful about agreeing too much with my colleague the member for Riverdale (Mr Reville).

I have no objection to proceeding in the manner Mr Carrothers suggested. He did approach both me and Mr Reville last week to see if we would be amenable to such a method of proceeding. However, I also cannot let the opportunity go by without saying that we have a very important piece of legislation with respect to health care in the future in Ontario, which was introduced, I believe, on 2 June 1988. We are now almost at the end of August 1989, almost 15 months later. I would have thought the government would have had its act together, especially with respect to the initial 30 amendments before it even introduced the bill on 2 June 1988.

There is no need for me to reiterate my speech of some two and a half hours long on second-reading debate of this bill, but I think a lot of the points I made there addressed that very fact. To me, it seems the bill was perhaps drafted rather hastily and a lot of problems were not considered initially. Obviously that is the case or we would not have some 30 amendments and a reprinted bill now. However, be that as it may, that water has gone under the bridge and I think we should proceed.

I am very interested, when we get into the ministry discussions here shortly, in hearing from the ministry about the way that sections 24, 24a, 24b, 24c, 24d and 24e dovetail with the subsequent sections in the bill, because I, like Mr Linden, who appeared before the committee last week, find it very difficult to read. We are having the benefit of a great deal of knowledge and expertise of officials from the ministry to explain what the bill is intended to mean, but I am very concerned about individuals out there in any health care profession who are going to try to make some sense out of this bill. They are going to run into exactly the same problems we have run into on first reading. I think if there is some way to improve the language or the way it reads, we should all be working towards that goal.

The Chairman: It has been moved by Mr Carrothers that we use the

reprinted bill, which is printed on the front cover, "Reprinted to show amendments proposed by the Minister of Health," which the committee had at the beginning of the hearings as the working document for the bill.

Mr Carrothers, did you have some concluding comments on that?

Mr Carrothers: Only to say that I appreciate the pragmatism of the other two parties. We are here to work together. I note that as a member of the government party, I am so pleased that we have been able to be so responsive to the public hearings we have just held.

The Chairman: I would like to thank all three parties for making my job a lot easier as chair by using this document. The clerk and I discussed this earlier; we knew the motion would be coming and he indicated to me that he feels it is in order to do this. We will proceed on that basis. Is there agreement?

Mr R. F. Johnston: Was there a motion?

The Chairman: Mr Carrothers moved the motion.

Mr R. F. Johnston: There was a motion, so we ought to have a vote.

The Chairman: Shall the motion carry?

Agreed to.

Mrs O'Neill: I have been trying to listen to every word Mr Reville has said, and I cannot quote back, but he said something to the effect that we are going to stick until we can agree. Is that what you said? What I am really trying to find out from this intervention is whether that is open-ended to the very end of page 31 or 32, or whatever it turns out to be, of the bill. That is what I am understanding.

Mr Reville: Yes.

Mrs O'Neill: And that is what you are trying to get our agreement on, right?

Mr Reville: I think that was agreed to.

Mrs O'Neill: Well, I do not know; I do not think it was agreed to, as there certainly was no vote taken on it. I am not sure everybody understood what was being said. This is why I am trying to clarify it.

The Chairman: My understanding, as chair, of what was agreed to is that we would go section by section through the bill, as we would normally do, we would take whatever amendments, we would debate and vote on amendments as we go through each section but we would withhold the final vote on "Shall section 1 carry?" until later on; "later on" yet to be determined by the committee. Later on could be as late as the end of the bill, and then we would go back and vote on all the sections.

Mr Carrothers: I think we would like to revisit tomorrow the question, if we could. Perhaps we will be able to clarify it then.

Mr Reville: I am happy to revisit this at any time, but I do want the committee to be mindful of the fact that if this seems difficult to do, it

can always be done again in the House. Every section can be revisited in the House. What I am suggesting is, let's save all that time and keep the sections open until we are ready to close them. That is the point.

Mr R. F. Johnston: Just to reiterate, if I might, I raise the COW prospect as well.

Mr Reville: Better explain what that is.

Mr R. F. Johnston: The committee of the whole prospect, of going through all of this one more time. This is not an unusual process we are talking about, and if the government was afraid of recalcitrant, obstreperous opposition not allowing this to go through, you should feel better about that process because of the very motion that Mr Carrothers moved which we then all entered into. If it was in our interest to hold this up for ever and a day, we would not have accepted his motion.

Mrs O'Neill: I just wanted to clarify what I had been trying to understand.

Mr Reville: Fair enough.

The Chairman: Before we move to some general discussion from each party and the report from the ministry on the newly tabled amendments, I would like to introduce for everyone our legislative counsel who will be working with us through the clause-by-clause, Mark Spakowski and Sidney Tucker. They are here to be of assistance to the committee as we work through these amendments.

Mr Reville: You did not introduce the Health expert.

The Chairman: I thought he had been introduced many times.

Mr Sharpe: I do not have a microphone.

The Chairman: We also have James Spence. Mr Spence, your title?

Mr Spence: Corporate health law expert. I am a partner in the Toronto law firm of Tory, Tory, DesLauriers and Binnington.

Interjections.

The Chairman: You are here assisting the ministry, I take it?

Mr Spence: Yes.

The Chairman: I think we are ready to begin.

Mr Carrothers: Perhaps we should start with the ministry's brief on the amendments.

The Chairman: I see nods all around, so we will begin with Mr Keyes. Would you take us through the amendments the ministry has tabled before the committee, that being the amendments in addition to the reprinted bill?

Mr Keyes: Rather than going through all those amendments, because many of them are of a technical nature and are the product of many hours of discussion by legal counsel, I may ask Mr Sharpe to do that. May I just in



introducing it say that I think the rationale for additional amendments coming forth at any time is a genuine reflection of the "cogent and strong" representations by people before the committee and by discussions within the committee and also within the ministry.

I think that justification is valid. We will know it will not have been exhaustive as we consider amendments from the two opposition parties, but perhaps if we are somewhat accurate in reflecting the presentations that were made and the discussions in committee in these amendments, we will be able to proceed apace with them and also perhaps to satisfy the majority of the concerns that have been raised by those appearing before us as well as those expressed by members of all three parties.

1450

I am going to ask Mr Sharpe to go through each of these. He will probably not at this time comment on how they may offset the concerns expressed by opposition motions, but I think the members themselves will see fairly quickly that many of the amendments tabled today will take into account some of the amendments that have been proposed by both the opposition and the third party.

I will ask Mr Sharpe to start, beginning with our section 1 amendments that we have in the bill as it is printed. I will ask Hansard if they are able to pick up fairly well from Mr Sharpe.

Interjections.

Mr Keyes: Why not just swap places?

Mr Sharpe: I will go through the government motions in order. We do not have the pages numbered. Hopefully, they will make some sense sequentially.

The first is the definition of an insured service. We have talked about this in the last couple of weeks. It has created some difficulties in understanding and perception, and perhaps I could start from the beginning very briefly and just bring us up to where we are now.

The Health Insurance Act currently defines "insured service" for doctors as services that are medically necessary. Even though there is a schedule of benefits that sets out a plethora of services that doctors provide and the government pays for, it is not that schedule of benefits that is referred to as to what an insured service is; rather it is the concept of medical necessity.

For practitioners under the Health Insurance Act, there it refers to services that are indeed in some way paid for through the Health Insurance Act.

When we were putting this bill together, it was considered very important to have a concrete notion as to exactly what services were covered to help us decide who is going to be grandfathered and, ultimately, who would qualify for a licence.

The original bill proposed to amend the Health Insurance Act to delete the reference to medical necessity and simply refer to what was set out in the schedule of benefits, as most insurance policies would set out the benefits at the back.

There were a number of representations made, primarily by the Ontario Medical Association, about how that might result in the government ultimately determining what the practice of medicine constituted. The reprinted bill goes back, therefore, to the original notion of leaving the Health Insurance Act alone as far as medical necessity is concerned for doctors, but in the interest of specificity and certainty in this act, setting out specific reference to the regulations prescribed in the Health Insurance Act.

Throughout the discussion by a number of groups at committee, there were representations made that suggested that perhaps it may be appropriate to ultimately add a number of groups to the concept of practitioner—in other words, community-provided nonphysician services by health care professionals other than doctors who may ultimately be licensed under this act and provide community-based services—and those services might be funded by a method other than fee-for-service under this act, under section 23, which is the funding mechanism.

That would require an additional amendment, under "insured service," to clause 1(1)(b). Right now in the reprinted bill there is a reference to: "for which an amount is prescribed by the regulations under" the Health Insurance Act. We are proposing to get rid of the reference to an amount prescribed under the Health Insurance Act so that it would enable us to fund these other practitioners under this act, according to alternate funding mechanisms such as a global budget.

In short, what we are proposing to do is take out the reference to "an amount is prescribed" to allow us to have some flexibility in terms of how we fund these other professionals.

The Chairman: Mr Reville, a question of clarification?

Mr Reville: I begin to see how the amendment is different from the previous amendment. Now it is not the amount that is being prescribed; it is the service.

Mr Sharpe: That is correct.

Mr Reville: To make this concrete for us, counselling would be an insured service normally rendered by a physician; at least, when you pay for it, under the Health Insurance Act that would be a service provided by a physician. There are other kinds of health professionals who can do counselling, psychologists, for instance, although that would not have been paid for—it still will not—as a Health Insurance Act payment.

Mr Sharpe: That is correct.

Mr Reville: But under this amendment you could fund it in some way. Is that more or less right?

Mr Sharpe: That is right. The last amendment in the package, if I can spot it, is the one that amends section 34 of the bill. What it is proposing to do is amend the Health Insurance Act regulation-making power to make it absolutely clear that we can prescribe things as insured services without having to pay for them under the Health Insurance Act in order to qualify those professionals for licensing under this act.

Mr Reville: To make this even more crystal clear, a doctor can do nutritional counselling and OHIP will pay for it; a dietitian cannot. But

under this amendment, that might be possible if you funded an independent health facility to do that.

Mr Sharpe: That is correct.

Mr Reville: That would be good.

Mr Sharpe: We thought so.

Mr Reville: So far so good. Keep it going.

Mr R. F. Johnston: You did very well with your first and last amendments.

The Chairman: Any further questions on that amendment?

Mr Sharpe: The next proposed amendment is simply intended to clarify some of the terminology that is used throughout the bill. "Medical care" includes health care. To be frank about this, again, during the presentations we heard from a number of nonphysician groups that made a very good case for ultimate inclusion under this legislation, so what we are attempting to do is take terms that are primarily physician-oriented, like "medical," and try to broaden them a bit.

For example, two of these definitions, "medical care" and "medical record," are interpreted now as meaning health care and a record relating to health services; again, so that no one might argue later on that they are to be given a restrictive interpretation. "Patient" is used and not defined so we have added the definition of "patient." Again, just for clarification.

The Chairman: Any questions on that?

Mr Sharpe: Section 2 of the bill deals with the exemptions. Under the act as now formulated, it permits various places to be exempt and the regulation-making power has a similar thrust: that you can exempt health facilities, which are defined as places. During the presentations, we heard some representation from groups like the Ontario Hospital Association suggesting that there be a clear exemption given to, for example, the corporate body known as the hospital and, as a hospital corporation, can do business, with some limitations under the Public Hospitals Act, throughout the province.

For example, Toronto General Hospital might have four or five sites. Rather than have to amend regulations every time a hospital opened or changed one of its sites, we are proposing to amend the regulation-making power and the exempting power to say that you can exempt a person as well as a place, a person including a corporate body person, wherever they may do business in the province. Again, it is a technical amendment to provide us with flexibility in providing for a range of exemptions.

The Chairman: Are there any questions on that one?

Interjection.

Mr Sharpe: Actually, the next motion also will clarify that: the proposal to add paragraph 2(2)5, a person or a class of persons that is exempt by the regs, to places.

Section 23: A number of groups, particularly several of the nonprofit organizations that came forward, suggested there should be clear authority to provide capital funding. Therefore, it is proposed that section 23 be amended to add capital costs to operating costs and services under the funding mechanism.

1500

The Chairman: Are there questions on that one? Next.

Mr Sharpe: The next series of provisions are actually over the next three pages of motions, and are intended to replace the government motion circulated defining "registrar."

The Chairman: Okay, to replace that. So that a was a previous motion tabled earlier. Are you withdrawing that one?

Mr Sharpe: I cannot withdraw them.

Mr Keyes: This is what we are substituting. There is much greater clarification of what we mean by---

Mr Carrothers: I do not think it was ever actually moved.

The Chairman: It was not moved, but it was circulated and I had it in my stack here.

Mr Reville: The amendment that was circulated on 8 August amends the definition of registrar. Is that what you want now not to move?

Mr Sharpe: Yes. But that would be replaced by the next three pages of motions that I am hoping to explain now.

The Chairman: Is everyone clear on that?

Mr Reville: The ones to sections 24b, 24c and 24d?

Mr Sharpe: That is right.

Mr Keyes: Just kind of chuck it.

Mr Reville: No, we keep that, to say, "Look at that."

The Chairman: I did not mean withdrawn, because it was not formally moved, but I have a stack here of all potential amendments so I will take it out. Okay. Would you explain?

Mr Sharpe: I believe it was the optometrists who circulated a list of amendments they would make to the bill in addition to "registrar" to broaden the base of those professional groups that could be brought into various parts of this legislation. I believe the notion was that if you had a clinic that was established, for example, by midwives or psychologists, it should be the governing body of those professional groups that reviews them and does their quality assurance and standards assessments and so and not the College of Physicians and Surgeons of Ontario.

The difficulty is that when the bill was drafted, it was drafted with the college of physicians and surgeons in mind; "registrar," of course, is



defined in that context, as is "college." In fact, there are some specific functions, such as subsection 24a(1), that deals with the inspection and enforcement of section 3 of the bill, where private doctors' offices are involved, and 24b(1), where the college on its own motion can appoint an assessor who has certain powers of entry to inspect records and so on, where it may not be appropriate to consider including other professional groups in a broad-based way, at least until the health professions legislation is down and one can see what type of governing mechanism is going to exist for those groups; because a number of those groups do not have a very well-formalized method of governing, reporting, accountability and so on.

What the next three pages of motions would do is focus on the most critical aspect of the bill where it might be necessary and appropriate to bring in other groups. Subsections 24b(3) and (4) and sections 24c and 24d seem to be those sections of the bill.

Subsection 24b(3) deals with when the director considers it necessary or advisable to do quality assurance and standards reviews. We are proposing to amend the provision to say that the director may give notice to the chief administrative officer of the governing, registering or licensing body of a health profession. In other words, it is when quality reviews are being contemplated that you would broaden out those groups that can be brought in to do assessments, and there the direction can go to any particular body including those that are not currently under the Health Disciplines Act.

That is the concept of the next three pages, the amendments to 24b, 24c and 24d. The concept, as I say, is the chief administrative officer of the governing, registering or licensing body of a health profession, which hopefully is broad enough. It is not just the Health Disciplines Act groups; it is any group that has a chief executive office of a governing, registering or licensing body and would include the psychologist under the Psychologists Registration Act and a number of other groups who appeared before the committee.

The next is confidentiality, section 30, which has two pages of amendments. It is proposed that section 30, as it currently stands, be repealed and in its place two kinds of protections be added.

One appears in the new subsection 30(3). Just to take the committee through, subsection 30(2) is the prohibition against communicating confidential information, which is defined in subsection 30(1). The way the bill is currently drafted, it would only provide penalties against those involved in conducting assessments and inspections in administering the act if they improperly disclose information. It would not extend to those who receive information from those people, properly or improperly. What we are trying to do in subsection 30(3) is extend that prohibition.

As you can see, it says that the prohibition in subsection 30(2) applies to any person, whether or not he was employed in the administration of this act or whether or not he was an inspector or an assessor. Anyone receiving confidential information is under the obligation not to disclose it with the penalties that are set out in section 31 applying to him. That is one half of it.

The other half appears on page 2 of this motion in subsection 6. The Statutory Powers Procedure Act that currently applies to tribunals, including the tribunals under this statute, has a provision allowing the chairman of the tribunal to close hearings where private matters that would be prejudicial to

an individual are going to be discussed. There is a balancing test. So we do not need to add this type of protection to the tribunal but we do to the court.

I believe a number of people raised the concern of a prosecution. An inspector goes into a premise, finds information of an offence—and it might be in relation to a health care service that is very private, for example, an abortion service—and the individuals to whom it relates then find the information being used in court to prosecute the person who improperly billed them for the service whether they want the prosecution to proceed or not.

What we are proposing in subsection 6 is to provide the provincial offences court with the ability to exclude the public from these proceedings where the information that may be disclosed is of such a nature that the desirability of avoiding disclosure, in the interest of the patient or former patient, outweighs the desirability of adhering to the principle that hearings be open. Of course, those principles have been recently articulated in the Supreme Court of Canada.

The old notion was that hearings are closed unless open was reversed. The court said, "No, there is a public interest that hearings be open," and that is what we are saying here, that we will not interfere with that unless to do so would involve disclosing information that would be against the interests of the patient or former patient. In other words, it is designed to protect the privacy of the patient so there would not be any press allowed in or anyone except the parties to the proceeding.

Those are the two proposed ways that we are hoping to address the many concerns raised about confidentiality.

Mr R. F. Johnston: It appears the government was moved to try to address some of those matters that were raised. Just for clarification, under the first change, do I therefore understand that this applies to members of the press?

Mr Sharpe: Yes. It would apply to anyone receiving information that came out of the inspections or assessments done under this act.

Mr R. F. Johnston: Is that the same as what we have in other acts dealing with clinical confidentiality?

Mr Sharpe: No, it is actually much stricter. Under the Mental Health Act or the Public Hospitals Act, for example, there are provisions dealing with the initial disclosure of the information, regulating who gets it and who does not and the exceptions to patient consent, but there are no provisions that follow the information to secondhand and thirdhand disclosures. In fact, there would be no protection against someone properly getting a patient's record with consent who then sold it to an insurance company or a newspaper, except private actions of breach of confidence if there were some duties owed, which often there are not.

1510

This is really the broader issue that I believe Mr Linden raised when he talked about the need for comprehensive confidentiality laws that might contain these kinds of protections for all patient information. But this is a first step. It is precedent for our jurisdiction to attempt to reach beyond the initial disclosure in protecting the privacy of the patient.

Mr R. F. Johnston: I was just wondering if you knew, as a health law expert, whether there are other jurisdictions in Canada which have this kind of law already and whether there have been any court rulings at all in terms of the freedom-of-the-press arguments. This is very strong power in terms of something which may be determined to be clinically sensitive information by the people who administer this act, but may be seen to be in the public interest by a publisher and not to be appropriately clinically sensitive.

Are there other jurisdictions with this kind of far-reaching law and are there any court cases that we could—

Mr Sharpe: I am not aware of other provincial jurisdictions. The only analogy I can think of is the Young Offenders Act that protects the privacy of the young offender and closes proceedings.

The Chairman: What about the recent hearings in Hamilton with respect to the refugee and the challenge by the Toronto Star?

Mr Sharpe: I am not familiar with the details. That is not health law. Sorry.

The Chairman: I just thought there was a precedent there.

Mr R. F. Johnston: In young offenders, there was always, of course, the traditional confidentiality of minors.

Mr Sharpe: Minors, yes. In the health care context, in terms of adults' health care records being protected, I am not aware of this kind of provision. That is to say, we are taking a bit of a step. I know it is in the material that has been used in Congress in the United States. They have had a confidentiality bill before Congress now for several years and they do view the record—actually, they do not look at the record so much as the information as being what is important, what has to be protected. They do feel that if you are going to protect a patient's privacy and confidentiality that it must be an absolute kind of protection, that the only override would be the kind of override that would be essential in the interests of justice.

We have taken a step like that in the Mental Health Act in 1978 where, if very private matters that could be injurious to patients are subpoenaed in court, the doctor can seek to protect that information and the party seeking it somehow has to convince the court it is essential in the interests of justice to override the concern of the patient's privacy.

We have had that in this jurisdiction for 11 years. To my knowledge, there has not been a charter attack on that. I should not say I am not certain who would bring it; obviously, the press would be the ones. But certainly the patients' rights groups have been very supportive of that provision as have psychiatrists and their organizations.

Mr McClelland: I think again to sort of flesh it out, my concern was almost the flip side of what Mr Johnston was saying in terms of the test. I am wondering, under the Statutory Powers Procedure Act and the general judicial test with respect to disclosure and privacy, if there is a range of tests, if you will. Under SPPA administrative law, it seems there has been a tradition that may avail itself of a greater degree of confidentiality than the courts might be inclined to provide. I think you began to deal with that. I did not want to sidetrack it because I think that is what you were addressing.

My initial concern would be the flip side of what Mr Johnston is saying: Are we going to arrive at sort of a sawoff at the cost of the protection to the patient and/or operator?

Mr Sharpe: The only experience I can relate to, again, is the Mental Health Act for over a decade. In that context, there has been upwards of 40 cases I am aware of where there has been an attempt to protect the patient's confidence even though there is some sort of judicial proceeding ongoing. In other words, some things have been said during the course of therapy that could be relevant if used in a subsequent court action, whether it is child custody, malpractice action or something else. It might be a divorce proceeding of some kind.

There the judges have developed a practice—it is not set out in the Mental Health Act—of an in camera, in chambers proceeding where they listen to the concerns of the physician about protecting the patient's privacy. If they are persuaded that harm could be done to the patient by disclosing the information, they go out into open court. Without of course revealing what it is that is in the information, they ask the party seeking the record to make a case to show why it is essential in the interests of justice that the concerns be overridden. It is a two-part process. I believe that except in rare cases where child protection is involved, the courts have tended to side with the concerns raised by the physician.

So I think there has been a balancing that seems to have worked fairly well. I think we in the ministry would have heard about it and there would have been some pressure to make amendments to the act if there had been some injustice one way or the other: Either too much was being held back or too much was being revealed. I would hope the same kind of balancing test would develop here.

Mr McClelland: And as you say, that is something you will obviously be monitoring closely—this is the first step—and you are prepared to act, I would think, reasonably expeditiously if there is current need for some adjustment or fine-tuning.

Mr Sharpe: Yes, I think if there was determined to be a major problem, hopefully we would be able to move on it very quickly.

The Chairman: Mr. Johnston, you had some further questions.

Mr R. F. Johnston: On the second approach here, it seems to me that the onus seems to be that only where the concern for the patient outweighs the desirability of adhering to the principle can the hearings be open. That seems to throw the onus back on the representative of the patient to basically prove that disclosure of this abortion or whatever the matter might be would be so significantly harmful that the fundamental principle of open hearings would be curtailed.

You obviously feel that that is not going to cause a problem, and it is certainly better than what was in the act up to this point, but I wondered if you could comment on that.

Mr Sharpe: My own preference would be what we have done in the Mental Health Act, to say that the benefit of the doubt should always be given to the privacy of the patient and that the court would only override that where—in some kind of language like we have used in the Mental Health Act—it is essential in the interests of justice that the hearing be open. It is a



slightly different test because in the one case under the Mental Health Act the information is not going to be disclosed at all; here it will be disclosed but behind closed doors.

I would think that if there was going to be a greater concern in terms of the ends of justice, it would be where it was not going to be forthcoming at all. There is a provision similar to that in the Young Offenders Act, by the way, where private reports can be presented to the court without necessarily disclosing them in open court but could be considered by the trier of fact in the case.

Again, I would prefer that type of test here where you are more heavily weighted in favour of protecting patient privacy, but a very brief review of the Supreme Court decision suggests that there is a very strong charter argument to be made that all hearings should be open. There is the Statutory Powers Procedure Act but, of course, it is dealing with tribunals and not with the court itself.

Here, when we are dealing with quasi-criminal prosecutions, it may be argued that there should be an onus on those seeking to keep the hearing closed that the test is met. It is a slightly different test than exists in the Statutory Powers Procedure Act. We have some extra copies of that, if committee members are interested in reviewing that act.

Mr R. F. Johnston: I would be interested in having a look at that. You obviously feel that this will have some impact on protecting the privacy of a woman who has been to a clinic for an abortion. You seem to think this will have some impact even though the Supreme Court ruling makes you curtail your language the way you have.

Mr Sharpe: I think in the draft that we have, we have probably taken it about as tight as we can in favour of patients, but it may be that even what we have is ultimately challenged. We would hope that the test we have for courts will be maintained. For example, if prima facie you were dealing with a very sensitive matter like an abortion rather than the implantation of an intraocular lens, for example, where the court would say that on its face the onus has been satisfied that the matter is very private, then if people were seeking to open the hearing so that they could reveal names and personal details, they would be fighting an uphill battle in order to overcome that presumption.

Mr R. F. Johnston: With some of the recent lower court rulings, I wonder if that prima facie benefit will be given to women. Anyway, I will think about it some more. Both of these areas are highly charged areas in terms of the questions they raise in my mind. I will think about them a bit.

1520

Mr McClelland: That having been said, I would just like to have my sentiment put on the record. If there is a possibility of looking at language that would be more akin to the historical parameters under administrative tribunals that might be brought to our friends on the bench and that err on the side of offending the sentiment of the Supreme Court—I do not think that it something you would fly in the face of knowingly and wantonly, but if there is an error to be made, it would be my wish that the error be made on the side of protecting the patient and then having that subject to challenge rather than going the other way and saying after the fact that we are losing confidentiality and let's try to close the door. In short, I would rather the

door opened by the courts than have the legislative process trying to close the door after the fact at the expense of a breach of sensitive issues.

The Chairman: We will have ample time later, Mr McClelland, for debate of the issue. At the moment, we are trying to clarify what the amendments are.

Mr McClelland: Yes. I am just saying that for consideration down the road. I want to express that concern up front so that it might be able to be dealt with and counsel may turn their minds to that issue.

Mr Sharpe: Section 31, penalty section: The first subsection in the penalty provisions reads, "Every person who contravenes section 3, 29 or 30 is guilty of an offence." It is being proposed that section 10 be added to the offence section. Section 10 deals with the nontransferability of licences. If someone does attempt to transfer a licence, he would do so contrary to this act, and it is proposed that that be included under the penalty provisions. Frankly, it was an oversight that that was not done before.

Similarly, subsection 6 is being proposed as an amendment to section 31; we are proposing to add that. Just to make the argument, if someone did attempt to transfer his licence for, say, \$1 million, a penalty of up to \$25,000 or \$50,000 may seem a small price to pay. So similarly to some of the income tax laws, it is proposed that in addition to those fines under the act, the fine not exceeding the amount of the consideration paid to the person would be added.

Mr Reville: They must be quaking in their boots.

Mr R. F. Johnston: You were in mean mood when you came up with that one.

Mr Sharpe: Section 33 we have discussed already, I believe. That was for the sake of clarity, indicating that persons as well as places can be exempt. This is the regulation-making power.

The Chairman: Yes. That was the first you mentioned.

Mr Sharpe: And I also mentioned section 34, which is a complementary amendment to the Health Insurance Act. Those are the government's proposed new amendments.

The Chairman: Mr Sharpe has concluded his summary of the government amendments. Are there any further questions on those presented?

Mr Reville: During our discussion of various matters that might obtain under this bill, we learned, I think probably from Dr MacMillan, that some insured services had two portions to them; one is the professional fee and one is a technical fee, which in the health law expert jargon—maybe not the health law expert but the health administration jargon—becomes a T fee. That is a particular amount. One of the kinds of things that a T fee would involve or one of the services that would have a T fee would be diagnostic radiology, for instance, where you get some money for the professional service and you also get some money for the cost of the film or whatever, maybe the cost of depreciation on the machine or whatever.

One of the concerns I have had is, having just requested from the Ontario health insurance plan and received a list of the billings to OHIP and

discovering that all the top billings relate to diagnostic radiology—they are enormous; one OHIP number had a \$4-million billing to OHIP.

Mr R. F. Johnston: They are good photos, I bet.

Mr Reville: There are a lot of T fees in there. I have not seen an amendment that relates to T fees. One of the ways to deal with a T fee would be to turn it into a facility fee, it seems to me. I guess I need the advice of Mr Sharpe or Dr MacMillan about where in the act one could attack that problem.

Mr Keyes: I am going to ask Mr MacMillan to make a comment.

Mr Reville: I think you have to call him Dr MacMillan.

Mr Keyes: We are close friends; I just call him Bob.

Mr Reville: Dr Bob.

Dr MacMillan: In my briefing to the committee, I did make remarks relating to the issue of two segments of rapid growth in our health care costs which were not at present captured by the legislation, and that was radiology and walk-in clinics. Walk-in clinics, I told you, from our investigation, have doubled in numbers in the past year. For Mr Reville's information, we did prepare, at his request, some more detailed figures for you.

I am not sure whether this is the document you are talking about, but it does indicate that there are significant increases in the radiology services on a private, entrepreneurial basis in the province as compared to the amount of growth in hospital radiology services. Indeed, in some communities they are actually in competition with each other, where the physicians and even the hospital-employed radiologist works out of a private clinic for part of the day as well, and is able to bill the system using, as is indicated, the T fees.

Several years ago, the government stopped the new development of T fees, partly because of the unacceptable growth in the use of these services and the tendency towards a volume-driven type of behaviour on the part of some practitioners. I have talked about this with legislative counsel and the minister, and it is not easy to adapt this legislation to this service unless one were in some way to determine that the T fee was to become a facility fee, and somehow tie that in with the act and grandfather the facilities that are out there now.

Clearly, the government and everybody would like the government to be a partner in the future growth of radiology rather than the situation as it presently exists, where we are a partner in the management of certain high-tech growth but we are not a partner in the growth of ultrasound and radiology. If someone has a licence to do radiology—in fact, a degree and a post-graduate degree—he can move anywhere he wants and start doing X-rays.

Mr Reville: This may not be the right place to debate this, but it is useful advice. As I look at the definition of "facility fee" in the act, there is no question that a T fee is a fee that "supports, assists and is a necessary adjunct, or any of them, to an insured service," because there must be several kinds of T fees that obtain in a number of services. My concern is that there clearly has to be a suspicion that the utilization needs to be controlled, that some of the films that are being produced of various people's bodies throughout the province might not really need to be produced but we have no choice but to pay for this under the current system.

My understanding about the growth in the amount of payout to diagnostic radiology, many of which are private concerns, would seem to support that. Perhaps, if that information is available, it would be useful for the committee to bring that forward in the next day or so. There might be a useful amendment that could be developed to deal with that matter which I would like to look at.

1530

The Chairman: I think Mr Sharpe had some clarifying comments on the point as well.

Mr Sharpe: The only comment I wanted to make was that it is currently possible under the Health Insurance Act to delete any reference to T fees and payments for them. If that were done, then the charging of any amount by radiologists in clinics for those services would run contrary to this bill, because I believe they would be construed to be facility fees rather than part of the insured service so as to offend Bill 94, and those clinics would then have to obtain a licence to operate under this act.

Mr Reville: That would require a complementary amendment, then.

Mr Sharpe: The difficulty is that they probably would not qualify for grandfathering under this act, because although they were operating on 2 June 1988, they were not at that time billing facility fees. What they were billing was considered part of the insured service under the Health Insurance Act; that is where the T fees exist in the schedule of benefits.

They probably would not be grandfathered. We would have to fashion some special provision for this bill or have to phase out the revocation of that regulation and, at the same time that is done, fashion proposal calls that would go out to the various areas of the province for licences under this bill.

Mr Reville: If it were the will of the committee to try to figure this out, it might be appropriate to get some advice from the ministry as to the most expeditious way to achieve that result. We do have a section of complementary amendments in the bill already. Another one could be added. The ministry might move by regulation, I suppose, and you might have to amend the grandfathering section in order to achieve that result.

I am not quite sure how to proceed in this connection. If that were the wish of the committee, then some work needs to be done to develop the appropriate mechanism. I guess I need the guidance of the chair. I suppose we could do it under definitions when we get there. I am just not sure at what point in the proceedings to raise this matter, get a sense of what the committee would like and provide the ministry with an opportunity to take a look at the matter. It may be the committee would like to see some of the information that is available so they can form an opinion about whether this is a useful thing to do.

The Chairman: We are going to go into general discussion before going specifically into clause-by-clause.

Mr Reville: I am just not sure, Mr Chairman, how the committee gives direction in this connection. It is a matter of concern. It may not be of as much concern to everybody as it is to me, but then again it may be. I do not know; we have not had a chance to debate it. I do not want to debate it now, but I want to indicate that I would like the committee to have that debate at



an appropriate time, and I wanted to give notice to the ministry officials about such information as is available and whatever suggestions they may have as to how to achieve the result, if that is the result the committee wants. I guess I have given notice.

The Chairman: You have certainly given notice of your intention or your desire. It may be something that needs to be caucused and for some interparty consultation to occur.

Mr Reville: Then why do we not just take this as notice and I will try to have a more practical speech ready for the next time?

The Chairman: Okay.

Mr R. F. Johnston: I think it is another good reason why we should keep the sections open as we go through, in case there becomes a consensus on this sort of thing. I wonder if that information Dr Bob talked about could be shared with the committee, so we can have an idea of the statistics around the growth in private radiology; I think that would be useful for people to see. Perhaps when we get down to definitions of "facility fee," at that time we might have a further discussion so people can ask appropriate questions and then we can always go back to it later on if people feel it can be open.

It did strike me, just from the small amount of the discussion I heard around the two matters; this whole question of radiology and the walk-in clinics. We were talking briefly after the committee ended last time, and I had asked for information about how many new nursing homes there were in the private and nonprofit sectors since we made certain amendments to the Nursing Homes Act which supposedly were going to make it easier for nonprofits to get involved. Again, this whole matter of walk-in clinics came up and the doctor said to me that this was the area of greatest growth that he had been able to notice.

If that is true, and this is our moment to move an independent facilities act, I just wanted to hear restated again by either the health law expert or the doctor just why it is we are not trying to include walk-in clinics in this bill. What are the problems with doing that? If one of the major *raison d'être* of this bill is that we want to try to get some control over this sector and this is the area of greatest growth, it seems to be a very large hole we have left for private-profit trucks to drive through.

The Chairman: Dr MacMillan, there has been a request for information and I saw you nodding. Is that information readily available and at what point could you have it available?

Dr MacMillan: Some of the information is available in brief form on the radiology. We have not prepared any documents on the walk-in clinics but will do so. I think we would need two days to prepare something worth while. The information on the nursing homes, as I told Mr Reville earlier, will be available tomorrow.

Mr Reville: I guess one of the problems with walk-in clinics is that, as far as I understand, they do not charge anything at all. They just bill OHIP. There is nothing we could call a facility fee unless there may be a T fee in there somewhere. Is that not the problem?

Dr MacMillan: That is partly correct, yes.

Mr Reville: What part is not?

Dr MacMillan: I meant it is correct, but in addition to that there is a great variety of types of walk-in clinics, everything from a doctor who decides to set up on a main street and make a sign a little bigger than average, to the type of person operating a clinic where you have a stick-on for your refrigerator and it is open until midnight providing every service to anybody who walks by.

Mr Reville: The refrigerator is open until midnight?

Dr MacMillan: We will try to put something together; I am sure it will be useful to the committee. If it were an easy task, I think some proposals may have come forth by this time, but we will present it to you.

The Chairman: Did you have any comment, Mr Carrothers, at this point?

Mr Carrothers: Not at this time. I think we have had notice from Mr Reville and there is much to consider in what he says.

The Chairman: I take it that we have concluded the presentation by the ministry of the amendments and questions thereto. Prior to entering our clause-by-clause consideration, we will begin with some general discussion, beginning with Mr Reville.

Mr Reville: I want to start by saying that throughout this committee process I have been grateful for the assistance that has been so readily given by the now famous health law expert and Dr MacMillan and other officials of the ministry. The information they have had was produced promptly and freely and we appreciate that, and some more information is going to be available and that will be of interest to the committee, I know.

We in the New Democratic Party, having gone through the public hearings and the ministry briefings and amending process to date, have seen no reason to change our minds from the speeches we made on second reading, which I believe, if I remember, were begun in November. Does anybody remember this? I know I made an excruciatingly long speech a long time ago and I think it might have been as long ago as November 1988. We then stopped discussing Bill 147 for a very long time and revisited it again in the spring. At that point, Mr Johnston made an excruciatingly long speech, I recall. It was a wonderful speech too.

1540

I guess from the sort of macro view, we find the bill disappointing because it fails to deliver on the rhetoric that has accompanied the bill. If I can refer you to a ministry document that you have all read and I am sure the government members have memorized, the ministry had three broad objectives, the first of which was described as a way to fund needed services and develop a more community-based health care system with district health councils participating so that the ministry can plan effectively for the future. The second was to ensure that patients receive quality medical care and that procedures are performed in a safe, effective manner, and the third was to regulate facilities so that they may be appropriately located and established in a manner consistent with a planned health care system.

With those objectives as my text, because those are the goals the ministry said it had for this bill, let me visit each of those briefly in

turn. Let me start by visiting the middle objective, because I think in that respect the bill is likely to achieve that goal.

Clearly the ministry has identified a problem, a problem that is likely to get bigger as technology develops and as various entrepreneurial souls and others less entrepreneurial invent ways to deliver procedures in a place that is not a hospital. We have seen the M. K. Bochner Eye Institute, for instance, now on Prince Arthur Avenue, which had formerly operated in the Park Plaza Hotel. There are some good reasons why you would both want to foster such an approach and also to regulate a facility that was performing those kinds of procedures. In the absence of a quality assurance committee that a hospital has, there has been no way to sort of walk into the Bochner eye clinic and say: "What's going on here? Let's have a look at it. What are your protocols? Are they appropriate? Is the amount of money this is costing appropriate?"

That is one of set of problems this bill will address and I think it will address them quite well, particularly since the amendments have come forward so that those professions that are not medicine will also have the involvement of their colleges so that a psychologist will be investigated by the appropriate college. That seems appropriate to me.

The other thing this will do incidentally is protect the health care consumer from additional charges, because those additional charges will not be allowed. That is of concern to the New Democratic Party given, as you know, our long-standing interest in accessibility to health care that should not be based on what you can afford but on what you need.

So those things are good. From a straight regulatory point of view, I do not think there is a whole lot wrong with the legislation, with the one exception of the concerns about confidentiality. It may well be that the amendments that have been tabled today that deal with secondary disclosure—we may well have landmark patient confidentiality legislation here, and if that is the case, then congratulations and I am proud of you all for being prepared to move in that direction.

When we get to the stage of the omnibus protection of medical information, we will see what we will see. These are difficult and important matters, and I do not pretend to be an expert in this connection, but you will have heard the concern raised about confidentiality of patient information over and over and over again by various people who work in the field and who seem to know what they are talking about, and we have to pay attention to that.

In terms of what you might call good housekeeping, I believe it is the Ministry of Health's obligation to ensure that they can do good housekeeping, that people are getting quality care, whether it is in a hospital, a doctor's office or an independent health facility. I am pleased to see that those matters are going to be addressed.

Regarding the other two objectives, taking the third objective first, I suspect that the talk about the appropriate location of facilities may be wishful thinking. The regulation in fact does not really go to the location, it seems to me. I think the proposal call exercise goes to where they are located; so there may be some inconsistency in that.

Most of the independent health facilities—we have to use that as a descriptive term because we still do not have a law that describes them—are located here in Metropolitan Toronto, I believe. In fact, I have not heard that any are not. But there are some operations that worry me outside of

Toronto. The operation that was described in Cambridge, if you will remember the glossy brochure and the doctor-investors they talked about, quite frankly is an offensive operation to me. I do not really think our public moneys should be supporting that kind of operation because currently there is no way to measure whether or not those services are appropriately offered. We pay for them because we have an insurance scheme at the moment. I am worried about the deployment of scarce resources in that connection.

In the main, the kinds of facilities that have been described to us are located probably here in downtown Toronto. Certainly the three abortion clinics are located in downtown Toronto. So ensuring that there is an appropriate distribution of independent health facilities is really going to be a function of how well the district health council process works or how well ministry-generated proposal calls work. Quite frankly, it is impossible for the committee to assess how well that will work out. It depends on whether you are an optimist or a pessimist. It depends somewhat on whether you trust the government or not. That may depend on which side of the House you sit on. It may depend on how you read the government's track record. You will not be surprised to know that I am a little sceptical about the bottom-line ability of the government to in fact ensure that the system is planned and that the facilities that come on stream are appropriately located.

Returning to the first objective, this is the one which has caused me the most unhappiness because, in fact, I am one who supports the government rhetoric, and my party has long supported the government rhetoric, to try to change the emphasis in the health care system and to shift the balance in the health care system. Our health care system has grown up as a treatment-oriented system, an illness-response system, rather than a wellness-creating system. Most of the money that we spend in health goes to deal with conditions after they have been contracted, to deal with trauma and illness. Quite frankly, I think we have created a system that in the main does that extraordinarily well and has done that in a way that has been as accessible as systems can be, with a few exceptions.

1550

What that has meant to our system, though, is that the concentration has been on medical intervention, on procedures, on high-cost, high-tech, high-volume delivery systems. To give the Ministry of Health a lot of credit, the OHIP system whereby people have been insured and professionals compensated for services they have delivered is among the most efficient anywhere in the world and in fact is used as an example to other jurisdictions. Would that they could achieve that kind of efficiency. The United States does not come even close to the efficiency with which professionals are compensated and the ease with which consumers of health care are covered. It will be even easier come 1 January on the consumer side. The current government and preceding governments, and the people who work in the Ministry of Health, need to be congratulated on the way in which that service is managed and the low cost at which it is managed. So congratulations in that connection.

What has been very slow to develop—although I am pleased to say that the amount of chat that we are hearing is increasing and increasing and increasing—is trying to create approaches which encourage people to take more responsibility for their own health, to create programs that prevent illness before it occurs. Again we are hearing lots of talk about it, but we have not seen put in place the programs that will make that a reality except in some very small ways.



It is only fair to say that the growth in community health centres has been rapid and dramatic under this Minister of Health, but we have to then say, "But the target is still modest." The target the ministry has is to serve four per cent of the population by 1992. Four per cent strikes me as not a big target, even though that would amount to a doubling of the community health care constituency. I think we have to do more in that connection. I do not see this bill as doing that. That is because the bill is primarily procedure-centred; ie, insured services. Those are services that are provided in the main by doctors, a few by dental surgeons in hospitals and some chiropractic. Those are procedures.

I think I understand the reason why this bill has to be drafted that way; they are trying to deal with the cataract surgery, mammography, laser surgery, abortion services, which are medical in nature, for which you can develop medical protocols and for which you can develop costing mechanisms that are empirically based.

It is much harder to deliver wellness services to people. The bill does not include any of the mechanisms that would foster that. I have asked about this a number of times. The minister keeps saying this will enhance community-based care. Basically, what we hear is a geographic criterion only; ie, it is not in a hospital.

There is nothing that smacks of community-based care, with all due respect, of the Bochner Eye Institute. It happens to be located on Prince Arthur Avenue. It could as easily be located on Perch Avenue in northern Manitoba. It does not relate to the Annex. It does not relate to any community. What it relates to is a number of people who need eye care who are referred there from wherever. It does not respond to community need, and it does not have any responsibility to any community. I am not singling it out except that it is an operation about which the committee knows, because Dr Stein was here. There are some compelling reasons why you can deliver cataract surgery in that way. I am not convinced, however, that will do us any real good in the long run.

What has been happening is that ophthalmic surgery is being pushed out of operating theatres by other, more dramatic surgical procedures like cardiovascular surgery, more emergency procedures. Some kinds of eye surgery are of a more urgent nature than others. Particularly if you have glaucoma and you have extraordinary pressure in the eyeball, you may need laser surgery to relieve that pressure or you might go blind, I guess. That would be done on an emergency basis. But most cataracts just make your vision disappear slowly, I think. I do not want to get too far out on a limb here because I am not very good on ophthalmology. That is only one of the things I am not too good on.

What is going to replace those eye surgical procedures in operating rooms? If we free up X number of hours, will that mean we are doing a lot more gall bladder surgery? Have we done the epidemiological study that guides us as to whether this is a good idea? In fact, there are some epidemiological studies that say we do far too much gall bladder surgery and that we should not be doing that but giving a less interventionist response to problems in the gall bladder. That is one example.

Should we doing as many caesarean sections? The ministry has shared with us some studies that indicate there is not a whole lot of rhyme or reason to the rate of caesarean sections if you go from county to county to county, and it may depend on the practice patterns of the particular obstetricians and gynaecologists. While it is a problem for our health care system that we have

not addressed, it is not going to be addressed by this bill necessarily. I would like to see a system whereby if a Dr Stein came forward, the funding of an independent health facility would require a corresponding reduction in the services that were appropriate at the hospital facilities nearby. I have received no indication of whether that is the way that is going to be done. It certainly does not say that in the legislation.

There is another problem as well, and we have certainly seen this in the mental health field, where traditionally we provided mental health services in hospitals and then the philosophy changed and we began to realize that keeping people for ever in a hospital was not very good for anybody; so we let them out. We did not have much in the way of community mental health services. In recent years there has been a realization that that does not make sense; so there has been a big bee on to increase the amount of community mental health services that are available.

What we have discovered, though, is that there is not a one-for-one tradeoff, and I think that is because there were people in the community who were not getting any service at all. So you put in a really good community service and you start serving people who had never before been served anywhere. In the mental health field, that meant people started coming out of basements and attics, quite frankly, and getting services in the community. So in fact we were not seeing those cost savings; we will eventually. There are probably all sorts of people out there who have cataracts whom we could now give cataract operations to if you set up enough eye institutes, one on every street. Whether or not that would leave us with a better health status at the end of the day is hard to say. You would want that to be measured.

When I discussed in the committee with the minister and others in terms of the community-based health care, the minister said that no, she was not prepared to mandate in the legislation those mechanisms which ensured that the community health care facility was responsible to the community, reactive to the community and responsive to the community. We all know that there are ways to do that. One of the ways is that you create boards of independent health facilities which are elected by the community. That is one way to do it.

#### 1600

These mechanisms are not described in any way in this legislation. It makes one tempted to agree with the Ontario Hospital Association that what this bill will really do is encourage high-tech, high-volume health care boutiques. If they were also high quality, then that would not be a negative quality, but it is not a particularly positive quality. What it does is just reinforce and re-emphasize the treatment emphasis of our health care system rather than the health promotion emphasis that the government says it would like to move to, an approach with which we would agree.

I guess that is my essential disappointment with the legislation, that it may well do, and I think it will do, a good job at regulating mainly procedure-oriented facilities. I think it will do a poor job in promoting real community-based health care, and to the extent that we very much need to move in that direction, then I find this bill extremely disappointing.

I have continuing concerns that the district health councils are not at all ready to take on the kind of responsibility that the ministry envisages they will have to take under this legislation.

Before you all is some useful information about district health councils

which I hope you will look at. If you look at who is on district health councils, their occupations are listed beside their names. I think you will find that, without wanting to criticize individuals in any way and without denigrating the contribution they will make, district health councils are not representative of any of the districts they serve.

There is a shortage of people with a labour perspective. There is a shortage of people of the first and second quintile. If you look at the socioeconomics of the occupational groupings of people on district health councils, they do not represent working people; they do not represent people on social assistance; they do not, in the main, do a very good job at representing ethnic groups and native people, and they have a limited ability to actually seek the views of the groups that are not represented there. That is because of the limited staff they have and the large number of assignments the government has given them.

It is fairly common, and I am not getting too involved in conspiracy theory here, but one of the ways to shut down an otherwise troublesome body is to give it plenty of work to do and not many resources to do it with. I know that district health councils have attempted to do the best they can, but I think I remain concerned that they do not have the resources and they continue to be unrepresentative and that is clearly not going to be dealt with as yet. I hope it will be dealt with.

In the end, I think we will have to wait and see what really happens. One of the concerns I am going to address through amendments is that I would like to see the Ministry of Health do an annual report in connection with independent health facilities so that the Legislature can be advised regularly as to which independent health facility proposals were approved, where they are, what they do and what the potential impact of that will be on institutionally delivered services. If the Legislature so desires, those annual reports could be debated by this committee or some other committee of the Legislature.

I cannot recall whether that reporting is allowed for in the bill. I do not think it is, but it seems to me to be a pretty basic kind of request of a ministry that is touting this as one of the instruments by which it is going to change the emphasis of health care in Ontario.

Let's see what proposals are approved. Those who do not get their proposals approved will probably be in touch with us because that is usually the way it works. We can then see how well the government is doing. It will be a useful tool for the government, as well, to see whether it is meeting its objectives.

I am not going to speak about reproductive issues because Richard Johnston is going to, except to say that is the one area in which current initiative could well be squelched by this bill. That irritates the hell out of me because reproductive issues have been an area in which the government has been very slow to act. That is why we have had a group that has been bugging government for over a decade about birthing choices that parents would like to have.

Initially, there was professional resistance to that, which was so determined that perhaps the Ministry of Health felt it could not move. That logjam has finally been broken and now, belatedly, in fact at the end of a decade, the government has said, "Yes, we now believe parents should have choices about where their children are born." Belatedly, the government has

said that the Independent Health Facilities Act will allow us to deal with the quality concerns.

Let's get a bit real here because we all know that midwives are doing home births even as we speak. That has been kind of winked at and it is being winked at because, quite frankly, there really are not serious health concerns about that.

In terms of abortion services, we all know that three groups of people moved to provide abortion services because they felt, and I agree, that government was not guaranteeing the access that women should have. This bill provides the minister with an absolute veto on any of these services, which in the hands of a minister with a particular ideology could be used to the disservice of women in Ontario. That worries me a great deal.

Mr Chairman, I may have gone on a bit longer than you would have wanted. The difficulty was I did not have enough time to make the speech shorter.

The Chairman: I understand. You did indicate at the beginning of your speech that you were sharing the official opposition time on the first go-round with your colleague.

Mr Reville: Yes. I wanted my colleague to take a little—

The Chairman: I will recognize Mr Johnston next to conclude the opposition party's opening remarks.

Mr R. F. Johnston: Fine. There are just a couple of things I would like to pick up on that Mr Reville talked about before I go into the reproductive issues a little bit.

One is that I think it would be very important to have an annual report mechanism put into this bill. It can be done in a number of fashions. It can be done as part of the annual report produced by the ministry or it can be one that is produced and tabled in the Legislature and made available to committees, and specifically, I presume, the standing committee on social development. If one is establishing this law for certain social goals, it would be very wise to have the measurement of that as much a public process as we can make it and have it come back to this committee, which will now be, of all the committees of the Legislature, the best prepared to deal with it. I would hope the government would look favourably upon that kind of amendment when Mr Reville produces it.

The other thing I wanted to talk a little bit about before I went on to the women's clinics is the whole question of the district health councils as the focus for the production of requests going up to the ministry.

1610

I saw with some interest the listing of the health councils that was circulated to us all. I went through each of them in some detail, and if you did, I think you would—there are some very interesting indicators of demographic and socioeconomic representation on those health councils. I wonder, because I have never seen one, whether the ministry has done any kind of analysis of the health councils that have been in existence since whatever year that was—1977; I cannot remember now, when we first established them in the province.



Mr Reville: Established with great promise.

Mr R. F. Johnston: I wonder whether we have done an analysis of their representativeness, any kind of analysis of their socioeconomic makeup, anything that would really show that as order-in-council appointments, they have in fact been representative. Those of us who saw this approach being used by the Conservative government of that time were quite concerned that the government was not establishing a devolution of responsibility in the planning of health care, but in fact was establishing a regionalized buffer—

Mr Reville: A flak-catcher.

Mr R. F. Johnston: —a flak-catcher to keep the government from concern around certain areas. They could always say, "The district health council is looking at that," or, "has looked at that," or whatever. But that group appointed by government would in fact not be the planning vehicles we want. Any analysis that has been done of the health councils would be very helpful to me at this point since they have been given such a pivotal role in this legislation.

I do not mean that you need to produce new information for me, but if there are reports and analyses that have been done by the ministry, which I have not seen in my 10 years here, I really would be quite interested in seeing them. It strikes me that before we proceed a long way in giving more power to those kinds of vehicles in our society, we should really have an analysis of whether they are doing the job we want them to do and whether they are as representative as they purport to be.

My concern, as I think Mr Carrothers noted one day in terms of my attendance pattern on the committee, has to do with my role as critic for women's issues for the New Democratic Party and my concern about this piece of legislation as it concerns women's clinics and the rights of women to access abortion.

The Supreme Court has decided that abortion is not a criminal activity and has decided that a woman has a right, a fairly unfettered right, to seek that medical procedure with the advice of and in co-operation with her doctor, and that existing curtailments of that right, as they are established through various rignmaroles of hospital committees or whether they were to do with the notion that clinics like the Morgentaler or Scott clinics were illegal, are no longer appropriate.

When therefore this Minister of Health (Mrs Caplan), who was elected on a fairly strong pro-choice campaign back in 1985, fairly visible, came under the normal attack that those of us who are pro-choice expect and welcome in election campaigns—

Mr Reville: Expected attack; not normal.

Mr R. F. Johnston: —and Mr Reville has been through that once or twice, and in each of my four elections I have experienced it to one degree or another—she withstood that and one had great hope that she would be a very strong pro-choice advocate. But when I saw this legislation come through in the first place, I got very nervous about this as a vehicle for really making access to abortion by women around the province sure, that by any measure of receiving equal service as the charter would presume should be available to women, this would in fact be a very double-edged sword. It was especially drawn home to me when I heard Mr Sweeney, a noted pro-life spokesperson within

the cabinet, indicating that as he saw this, this was a guarantee that there would never be more than two abortion clinics in Ontario.

I was very disturbed, as you know, in the first meetings here with the minister, when the Canadian Abortion Rights Action League came before the committee, as one of the press articles indicated, the minister did not use the word "abortion" once in that whole exchange or in interviews afterwards. There was no major statement that the government was committed to making sure that access was going to be made available across the province and that independent clinics were an appropriate means of doing that. There is no statement, for instance, by the minister.

It bothers me that if you look at southwestern Ontario in the Windsor area, the group that is looking to establish a women's clinic in that area is a hospital that took on a number of services recently in agreement with the local Catholic hospital on the basis that it would not do abortions in that hospital. That is the group that is working on getting a women's clinic in that area at the moment, an area that is terribly underserved in terms of access to abortion and an area where many women go to the United States at this point.

I saw a number of groups, for which I have great sympathy, come before us asking for certain amendments around appeals and that kind of thing within the act to make sure that the powers of the district health councils, as they are established here, their responsibilities, would not be used to stop clinics from being established.

But I say to members, as I said to Dr Morgentaler when he was here, when you look at the reality of what a health council will have to face on this issue locally, and when you think of the range of requests that are going to come before it in terms of independent facilities, to imagine that an appointed health council is going to have the courage to withstand the controversy and debate, and therefore come forward with initiatives in the area of women's clinics, I think is dreaming in technicolour, or it has to be looked at, as Mr Sweeney sees it, as the real means of stopping any further development of these kinds of clinics.

If you think that is not the case and you wish there to be greater access, as I know certain members on the other side of this committee do, then I just say to you that I think you are mistaken. If you are relying on the minister and her capacity to initiate to be the grounds upon which you are hoping this further access will be guaranteed through independent clinics, I suggest to you that her performance—the committee was not given any indication that there was going to be great movement in that area, and as you all know, with the vagaries of politics as they are, she, even if that were her will, is not going to be minister for ever.

Things change. Who would have thought a year ago that we would have seen the wholesale change in cabinet that we have seen. I know a number of you wanted a wholesale change in cabinet, but then did not want to be sitting here listening to me now after that change took place, but these changes do occur. We may not have the protection of a minister who is pro-choice in this matter in the future.

There are a number of ways the government can move on this if it chooses to, and it would make me feel better before we get to clause-by-clause—

Mr Reville: We could go home, withdraw the bill.

Mr R. F. Johnston: Yes, these are options.

I was suggesting and the groups were suggesting that what we really needed was a major statement by the government that it would make sure no region of the province would be underserved, that clinics would be established and that the government would make sure those clinics were established, and send that directive out to district health councils in areas where those clinics are not available, that this was one of the things they must do in this first group of presentations that are brought forward and that they would not be penalized by holding back other kinds of facilities if they agreed that a women's clinic to provide these kinds of services would be brought forward.

I have not heard that statement as yet. I would love to hear it clearly enunciated. If I heard that, it would make me feel a great deal more comfortable than I do at the moment about how this legislation will be used.

The other possibility is for the government to—I thought by amendment, but it appears to me that it does not even require an amendment at this point—indicate that for the meantime these kinds of services, reproductive services for example, would not be included as part of this act. In other words, we would get in place first a whole series of these clinics.

Special changes to funding arrangements could be made through changes to regulations that apply elsewhere, to make sure the money was available to help these be established; the government could move on that if it chose to without legislative change. After they were in operation, they could be deemed to fall under this act after a certain period of time.

1620

If there were an amendment to be made, it would be a timing amendment, or it would be quite simple under subsection 2(3), it would strike me, to say that a certain group or class of services is exempted by the regulations. The regulations could very specifically exempt them for a period of time, until such time as the government was convinced that equal access to these kinds of facilities was available across the province.

This is slightly more complicated, obviously, and would require some action on funding of health service organizations, or some other model, to make sure that these clinics could function, but it would be a second route that could be taken.

The least I would want to hear at some point before we finish here in our clause-by-clause would be that the grandfathering provisions would apply to the Colodny clinic. I think it would be just the most terrible irony if after this enabling legislation, we actually ended up with two instead of three independent clinics providing abortions in Ontario. Surely, as we come to the end of our deliberations, the possibility of identifying that clinic in addition to the birthing centre as grandfathered within the bill would be an obvious move that would be accepted well by people in the pro-choice community and obviously people who have been looking for some choice in birthing arrangements as well.

I just say to the chair and through you to the government that I am not going to move amendments until I hear where the government is going on this, but if necessary I will move amendments that do not deal with this by regulation, but state within the act that these clinics are exempted for a certain period of time.



Mr Reville: And in the House too.

Mr R. F. Johnston: And in the House as well. But I cannot understand how a government and a minister who has been fairly strong on the issue of choice will not make some kind of statement that the present problems we have in access—you know that they are still enormous, that there are whole regions of the province where a tiny minority of hospitals provide abortions—that this bill will be used to redress that, that it will be a stated policy of the government that this must be done, that health councils will not be penalized for other kinds of facilities they may wish to involve themselves with and that the government will stand behind them and will take steps on its own, if health councils will not move in those areas, to ensure these kinds of clinics are established.

If that does not come forward, then we will move the appropriate amendments to basically put the law to the Liberals' supposed pro-choice position. I would say to you that this is not a time when we need that kind of confrontation, the kind that women in this province and in this country have been put through lately, by provincial superior courts especially. This is a time when we should all be basically, I hope, circling our wagons and saying that that sort of thing is not what we mean to do as governments and as legislators, but rather that we want to provide the supports necessary to women who make that most difficult of choices.

This is just a little plea that rather than having a confrontation on this issue, perhaps we can come up with a consensus and the government will have the courage to make a statement. They should know if they do that they are not out on a limb on this by any means. If my statements in the past have been any indication, you know that I am not afraid of negative publicity on this matter at all but believe it is time we stood up and stood up really strongly. A mealy-mouthed kind of approach to this at this time is exactly the wrong message to be sending out to women in the province.

Mr Eves: I would like to make a few general comments about the legislation as a whole and then I would like to try to explain some of the rationale behind the amendments we have tabled today, and perhaps, if there is time today, evoke some sort of response from the ministry officials so maybe we can decide which way it would be preferable to proceed.

First, we have heard quite a few things from a lot of the groups which appeared before the committee in hearings. We have heard opinion that ranges from, "The act will do nothing to expand traditional community health programs, such as health promotion and prevention, home care, to name a few." We have heard from the Ontario Nurses' Association and Glenna Cole Slattery, indicating that the bill does nothing to promote the nonmedical model of health care; in her phraseology, "This bill is about sick care and not about health care."

We have heard from others that this bill will do little more, in their view, than set up a system of mini day surgery hospitals around the province. We heard the concerns from the Registered Nurses Association of Ontario that the title of the bill perhaps should be changed to the independent medical facilities act as opposed to the health facilities act.

Hopefully, some of the amendments the ministry has tabled here today and some of the amendments that we may or may not consider, whether introduced by myself or others, will address some of those concerns.



We heard from numerous different individuals and groups that concern about whether independent health facilities are going to be cost-effective. During the briefings, I believe the minister said they would definitely be cost-effective, but we have also heard officials on her own staff say that no one could be sure of the cost-effectiveness at this stage.

The increased popularity of mini day surgery hospitals, if you want to call them that, as some people did, is likely to result in increased billings to the Ontario health insurance plan and therefore put a new demand on scarce health care dollars.

On the other hand, some groups have told us that they see this bill as a way to control the number of medical procedures being performed outside of hospitals and in effect thus control OHIP billings and health care dollars.

Under section 5 of the bill, which details the items the ministry must consider as part of the proposal process, no one is required to consider the cost-effectiveness of the proposed facility. As part of the process of considering the cost-effectiveness of a facility, perhaps it would be wise to also consider the impact the proposed facility would have upon existing services. We heard much about that from hospitals, for sure, as well as other concerned groups.

Protecting patient confidentiality was an issue that many individuals appearing before the committee were concerned about. The bill allows for ministry and/or college or the appropriate governing or licensing body of a profession to allow inspectors and/or assessors to enter not only licensed independent health facilities but all health facilities and seize samples and records.

Almost nobody who appeared before the committee was satisfied that patient confidentiality was adequately protected. I was very impressed by the position Mr Linden took and brought before the committee. I thought he was very direct, independent and honest in his assessment. I certainly share his concern that when you try to read through certain portions of the bill, especially when you start at section 24 and go through some of the ad hoc amendments that were added later, 24a, 24b, 24c, 24d, 24e etc, it is very confusing.

1630

If it is confusing to Mr Linden, I think it is going to be very confusing to people out there with no legal background, who are not going to have the benefit that perhaps we are going to have in these hearings, of having explained to us what the intent is; nor is our judiciary, in the future, perhaps, when it interprets certain sections of the bill, going to have the benefit of that knowledge either.

I believe we were told by some ministry officials and by the minister herself, "Perhaps we shouldn't concern ourselves with this, as we're going to introduce an omnibus bill which will cover the whole issue of confidentiality in the health care system, hopefully this fall."

If indeed that is the intent and we are being asked in good faith to rely upon that omnibus bill perhaps to correct some defects in patient confidentiality that may exist in this proposed legislation, I do not consider that to be either a very methodical or adequate way of introducing legislation. Perhaps we should get the horse before the cart instead of the cart before the horse.

We have also been told at various times that there is no need to concern ourselves about different parts of the legislation because, when the appropriate health professions legislation review comes through, those inadequacies, or perhaps gaps, in the legislation will be filled at that point in time as well.

Another concern I have is that of the role of district health councils in the whole process. We have heard diverse opinions as to exactly what role DHCs will have to play in this whole process. We have heard from the parliamentary assistant to the Minister of Health that DHCs would have no role to play in the licensing or grandfathering of existing independent health facilities.

On the other hand, we heard from the association of district health councils that their interpretation, and they had been told by ministry officials, that they would be commenting on every single independent health facility, grandfathered or not, and that they would have very real input into whether or not those existing facilities were licensed. I do not know how you balance those two divergent impressions as to what their role will be.

I am somewhat concerned about a few other issues. One was the issue addressed by several health professionals of transferability of licences, profit versus nonprofit. I think that almost everybody would prefer to see the bill providing those services where required. I suppose the point where I disagree with my two friends to the right is that on some occasions I can see where the only way a particular service may be able to be provided is through a for-profit organization. That is why the bill is drafted the way it is and I support that.

We listened to the concerns of hospitals on how they may participate in this process and they were very concerned that they might be shut out of the process. It was suggested to them that perhaps they could participate through their foundations, depending on the objects of their foundations. I think the legal advice that was given by Mr Sharpe was very appropriate in that regard.

I am concerned about including health facilities other than those run by physicians in the legislation, and I think the ministry is starting to take some steps to do that.

I am also somewhat concerned about some of the Big Brother aspects of the bill, without the appropriate safeguards or appeal process.

Those are the general observations I have about the legislation. I would like to try to take committee members very briefly through the amendments we have tabled. Some of these amendments will not be necessary, hopefully, if we can be convinced that the amendments the ministry has introduced are just as good or better. Others will not be necessary if certain others pass or fail.

Starting with section 1, very simply, the four amendments we have tabled with respect to subsection 1(1) really just amend definitions of the words "college," "health facility," "practitioner" and "registrar" to try to include any health profession or facility, not just those run by physicians.

I would be interested, after I am through, which will not take very much longer, in hearing from the ministry. I note they started to go down that route with their proposed amendment initially for the definition of the word "registrar." I would be interested in hearing from them why they have chosen to go the route of amending those other sections. Perhaps they feel that

amending the definitions section is an adequate route to go. I would be interested in hearing those comments.

The next amendment we have in our package is on section 8. In subsection 8(1) and subsection 8(2), all I am really proposing is that we go back to the original bill as drafted. In the original bill, there was a requirement that written reasons be provided by the director at the time that an appropriate proposal or licence is approved, rejected or revoked. I did not see anything wrong with that. For some reason, that proposed section 8 was rewritten so that the director now only has to indicate to the person or individual that he or she has been approved, rejected or revoked but does not require written reasons unless the person requests them within seven days. I think I would have preferred the bill as originally written.

On section 9, the amendments we are proposing are very confusing, even to myself. What I really would like to know is what the intent of section 9 is. It gives the minister some very wide powers, or at least would appear to. I do not know if this applies to the situation where the minister decides that having asked for proposals about a specific type of facility or in an area, he or she decides, "I'm not going to go ahead with this proposal idea, period, so that means that nobody who introduced a proposal will be accepted, because I'm backing off of the ministry's original concept." If that is what it means, I do not have too many problems with section 9, except to suggest that it could perhaps be better clarified. I have attempted to do that with the amendment I have suggested for subsection 9(1).

If, on the other hand, section 9 could apply to the situation where the minister decided that he or she was not going to issue a licence to a specific person or persons but was going to go ahead with granting such a licence to someone else, then I have some problems with the section, because I think the powers it purports to convey to the minister are too arbitrary and without appeal. My remedy for that would either be to strike out the section in its entirety or it would be to introduce a subsection 9(3a) which would in effect use the same appeal process that has been used elsewhere in the legislation.

I would either strike out subsection 9(5) in its entirety or amend it to indicate that section 8, the provisions for the appeal process and notice that had to be given, etc, would definitely apply to decisions the minister made as well; whichever method of proceeding legislative counsel would deem to be most advisable.

1640

The other group of amendments I have not tabled, because I just got them, but which I will table, purports to deal with transferability of licences in section 10, because I feel quite strongly that a licence should be transferable, especially if you are going to have some continuity of particular health facilities. If you amend section 10, and if it is the wish of the government that such a transfer may even be thinkable and it may be willing to entertain such an amendment, then that would necessitate other amendments later on in the legislation, such as section 19 and section 23.

The next section I want to deal with is section 18. There again, it is a fairly arbitrary power, in my opinion, granted to the minister, where he or she may direct the director in writing not to renew a licence. I have purported to take out subsections 18(4), (4a) and (4b) of the bill as it is printed and substitute it a subsection 18(4) which in effect would provide for the same appeal process that exists elsewhere in the bill and the same appeal



procedure, I might point out, as is in the Nursing Homes Act of Ontario.

This is also outlined in subsections 17(4) and 19(2) of the bill.

Section 21 is the next and last amendment I have prepared to date. In subsection 21(1), I would prefer that a decision be appealable on a question of law or fact or both, not just on a question of law.

In subsection 21(5), if the committee should decide that it is willing to entertain some amendments I have introduced with respect to appeals and the appeal procedure that would result from a decision by the minister, then I am proposing that the minister would be entitled to be heard upon argument of an appeal, the same as he or she is entitled to be heard under subsection 9(3) of the Nursing Homes Act.

Those are my submissions for amendments to date. I do not have any surprise amendments, other than the fact that I still would like clarified this whole issue starting with section 24 and going right through. If I am happy or satisfied, I guess, and understand what it is trying to say and I agree with that principle, then I suppose I will not have any more amendments. If am not, then I may have some more.

I would be willing to hear a response from the minister, if that is the chairman's wish or the committee's wish.

The Chairman: As I understand it, Mr Eves, as part of your comments you are seeking some response at this point which may assist you in determining whether further amendments might be drafted on your part.

Mr Eves: That is correct.

The Chairman: I will just seek to see whether the government is prepared to comment on any of those at this time.

Before I do that, I have had two or three members ask me when we are going to recess today, so I will seek the direction of the committee at this point. We could recess now or we could conclude with some ministry comments on Mr Eves's request. Then I have three speakers from this side yet to hear. What is the pleasure of the committee?

Mr Eves: I am in your hands, Mr Chairman. If the ministry feels it can comment on all of them at this time, that would be appropriate, but if it does not, I am prepared to wait until tomorrow.

Mr Carrothers: We should hear, if we could, from the ministry until perhaps five o'clock.

The Chairman: And then hold off the three comments until tomorrow morning?

Mr Carrothers: Why do we not see how long it takes? It may be that the comments could be done as a package.

Ms Poole: If I could just beg the indulgence of the committee: I will not be sitting for the balance of the week, and I did want to make a very brief comment. I am happy to do it either now or at the conclusion of the ministry's presentation.



Mr Keyes: We will be able to respond in five minutes' time.

The Chairman: Carry on then. You are on, Mr Keyes and ministry staff. Who are you delegating this to?

Mr Keyes: Mr Sharpe will commence dealing with the section 1 amendments.

Mr Sharpe: I will try to speak quickly. On the initial comment about why we are substituting for the original motion on registrar a series of other motions, I am happy to repeat what I said earlier. We have three motions in the middle of our package entitled sections 24b, 24c and 24d. What we indicated at the time was that the original notion of registrar, amending that and expanding it to include all of these other professional groups, at first blush appears to be a sensible way to go. But when we looked at the bill we realized that the bill initially was written with the College of Physicians and Surgeons of Ontario in mind, certainly the Health Disciplines Act kinds of governing bodies. Many of these other health disciplines, although ultimately if the health professions legislation review come to fruition will have the same kind of status, currently do not. It would be very difficult to grant those other groups the kinds of investigatory status throughout the bill that changing the definitions would do.

What we were proposing instead was to look at the most important sections of the bill as indicated in the submissions by some of these groups. In other words, where is it fundamental to their operation that these other professions be able to play a role? It seemed that the most important sections were in section 24, when dealing with quality assurance reviews. We took section 24b(3) on page 19 of the bill and deleted the reference to the registrar of the college—both terms are currently defined in terms of doctors—and substituted the notion of a chief administrative officer of the governing, registering or licensing body of a health profession, a very broad generic kind of reference.

It does not even bring it to the Health Disciplines Act; it is broader than that. Any health profession that has a governing, registering or licensing superimposed body to it would qualify for the director to bring them in and do quality assurance reviews of their profession or their health group within these clinics. But to broaden it out and have many of these other groups that really do not have the kind of accountability controls that exist, for example, in the Health Disciplines Act, and move them into sections 24a and 24b, where in section 24a, for example, you are inspecting nonlicensed doctors' offices, and in section 24b, when the registrar or the council is able on its own to appoint assessors who have the powers to enter facilities and look at records and so on, when some of these groups themselves do not have the kind of accountability one might want, would be fraught with difficulty. So it was suggested, as I say very briefly, that we would deal only with section 24b(3), the quality assurance assessments triggered by the director, and there the director would be given the power to bring in some of these other groups, just by way of explanation as to why that was done.

There were some questions about sections 8 and 9. Very briefly, the main reason why subsection 8(1) deleted in the reprinted bill the reference to providing written reasons in every case, frankly, was administrative. This would be similar to the sort of provisions that exist, for example, where a doctor applies for privileges at a hospital and is turned down. There are not necessarily reasons given in every case, but the doctor is entitled to write to the board and ask for written reasons and is entitled to receive them and

then, if he is not happy with the reasons, to appeal.

We are advised that there are significant administrative difficulties in having to provide written reasons every time one is responding to proposal calls in terms of the winners and losers. The model set out in the reprinted bill in subsection 8(2) does give anyone who is dissatisfied the right to receive written reasons, but one would simply have to trigger that right by asking for the reasons. That is similar to what exists in a number of other statutes.

On subsection 9(1), I believe that Mr Eves's first interpretation of that was correct. It says any time after the minister requests proposals the minister may direct the director in writing to not issue a licence to any person; by implication it means any person who has responded to a proposal call. So the intent was consistent with the amendment moved and with the first interpretation that Mr Eves presented to that.

I could go on to some of the other amendments that have to do with whether or not the exercise of government or ministerial discretion should be subject to review by an administrative tribunal. I would be pleased to do that if you wish. I have made that speech a few times here already.

The Chairman: If it would help clarify Mr Eves's questions.

Mr Sharpe: Would you like me to?

1650

Mr Eves: I suppose, as Mr Sharpe has said, I appreciate that those issues may in fact be ones of policy as opposed to legalities.

Mr Sharpe: That is correct.

Mr Eves: I would be interested in hearing from legislative counsel what their interpretation of the words "any person" is in subsection 9(1). Does "any person" mean any and all people who submitted a proposal or could it be interpreted to mean any one or two or three people who submitted a proposal?

Mr Tucker: The interpretation we placed on it was the first one put on by Mr Eves and, as Mr Sharpe has explained, it means any person or all persons who have submitted proposals, definitely not one particular person.

The Chairman: Is that helpful, Mr Eves?

Mr Eves: Is there some other wording that might make that clearer? If somebody says to me any person can walk down to Bloor Street, that does not mean that everybody in the world walks to Bloor Street. It means that any one person could do that if he or she so desired.

If your intent is to mean that any and all people who submitted proposals can be told that we are not accepting any proposals in this, I accept that. That is a decision that the government should be able to make. I just would like the language to be a little clearer to say exactly what it means there about any and all.

Mr Tucker: Frankly, it seemed to us at the time that it was clear as it stands. The language is flexible. You might equally stop after the word "licence" and just simply say, "to not issue a licence," and have the same result.

Mr Eves: You use the words, in subsection 9(3) later on, "shall refuse to issue a licence to any person and shall give written notice to every person who submitted a proposal," etc. If we could make the wording of those two sections somewhat consistent, I would be happy as long as I am satisfied in my own mind that that is what it means. I have no problem with it meaning that.

May I comment on a couple of other points that Mr Sharpe made?

The Chairman: Carry on.

Mr Eves: With respect to section 8 and the notice, I appreciate that it may lead to some administrative problems. However, I feel fairly strongly that people who submit proposals are entitled to know in writing why they were rejected. I do not suppose you are ever going to get a huge demand from some successful proposal, but I am sure that you are going to get a lot of requests from unsuccessful applicants and I would like to see that addressed.

There is no time, I believe, stated—I stand to be corrected—by which the ministry or director has to respond to requests in writing. There are time limits that hearings can be requested in so many days after receiving written reasons, but having had some experience with government—this is not to say that I understand the way government operates and sometimes these things take time—we could be dealing with the facts and the hearing in this thing long after somebody had lost out on an opportunity to have a successful proposal, especially if that decision is overturned on appeal of some sort.

I appreciate what you are saying, but I prefer that it be tightened up one way or another. That is just my personal preference, of course.

I appreciate your comments about section 1 and sections 24c and 24d, I believe, or sections 24b and 24c. You do not feel that it is appropriate, I gather—you have said so—to attack or deal with the problem that exists in section 24a as well with respect to other health care providers or professionals. Is that correct?

Mr Sharpe: Yes. The section 24a provision, of course, is inspection of unlicensed facilities, subsection 24a(1), and essentially what we are looking at there are private doctors' offices. So to provide a plethora of other groups the opportunity to enter doctors' offices, groups other the College of Physicians and Surgeons of Ontario, at this point is beyond the intended scope of the bill.

I think if the time is reached—I am just speaking from a legal perspective—that we have a health profession statute that broadly embraces a number of other groups and ultimately those groups do have proper accountability status under the new statute and do receive licences and then it is necessary to enforce the statute against unlicensed practitioners of those groups, then perhaps it might be appropriate to amend this bill complementary to that new status in the new health professions legislation.

Mr Eves: I quite agree, except that it seems to me that on several occasions in these proceedings, the ministry is telling us: "Don't worry about confidentiality. Trust us. When we bring in our omnibus bill, those problems will be dealt with. Don't worry about the health professions legislation review. Trust us. When that bill comes in, we will deal with that problem."

I am a pretty trusting sort of guy, I guess, but like Mr Reville—I have

not been around here as long as he perhaps, but I have been around here a long time and regardless of what government has been in power, government moves very slowly on occasion, as we can even see with this particular piece of legislation. We may be sitting here 15 or 18 months from now and never see the reality of the omnibus bill to protect patient confidentiality loopholes or cracks that will be in place after this bill is passed. We may never see the HPLR stuff within the next 15 or 18 months become reality. I am sure we all wish that we do, but reality being what it is, we may not. I would prefer to try to deal with that now as opposed to waiting for whenever it might happen, be it 18 minutes or 18 months from now.

Mrs LeBourdais: I am going to wait until tomorrow to make my comments, because they really were in response to Mr Johnston's comments and I would prefer that he were here when I make them. I believe Ms Poole has some comments she would like to make, so if I could hold my position for tomorrow.

Ms Poole: I too regret that Mr Johnston is not here. Apparently, he had to go and pick up his baby, which is a laudable aim, but he shall read my attack in Hansard. I just could not let his comments go personally unchallenged.

I truly believe he believes in what he has said. He feels that instead of opening up access to abortion in Ontario, in keeping with the spirit of the Supreme Court decision, there is instead an ulterior motive on the part of the ministry, mainly on the part of the government, to close down the abortion clinics in Ontario. I would like to give a number of reasons why I think this is absolutely not true.

The first is the very fact that the Morgentaler and Scott clinics were grandfathered. I would think if the ministry or the government were intent on closing down abortion clinics, that would have been the first thing that would have been missing from the legislation. The fact that the Colodny clinic was not grandfathered I think is fairly understandable, since it had not been opened at the time of the grandfathering date, 2 June 1988.

In fact, Dr Colodny opened up, knowing full well what the legislation had to say and what the grandfathering date would be. I am quite hopeful personally that when proposals are called for, Dr Colodny will meet the criteria and the clinic can remain open.

The second reason why I feel that Mr Johnston is wrong in his supposition is that there are many members of the Liberal government, including quite a few on this committee, who could not support this legislation if that were indeed true.

The third reason is the minister's personal position. I think if the opposition members will turn their minds back to the election in 1985, they will remember that the current Minister of Health (Mrs Caplan) fought an election on this very issue.

Mr Reville: He said that?

Ms Poole: I said that.

Mr Reville: He did too.

Ms Poole: But I think it goes beyond what Mrs Caplan's personal position is. I do not think this legislation is at the whim of a minister.



There is a very important consideration in this regard and that is that the voters, if they feel the minister has taken an inappropriate position and is either attempting to close down clinics or not open up clinics where one is necessary, they will have the final say in this regard.

I think the other thing that has not been said is that Ontario has taken the lead in this issue. If you will recall, within days of the Supreme Court decision coming down, Ontario, unlike many of the other provinces, had declared that the health insurance plan would cover abortions. I think we have also taken the lead in areas such as midwifery and other women's reproductive rights issues. It may not happen as quickly as many of us would like, but as Mr Eves pointed out, that too is one of the difficulties of government: it does move slowly.

I guess I would just like to close by saying that I do not personally believe that the New Democratic Party is the sole bastion for protecting women's rights, whether reproductive or otherwise, in Ontario. I can assure the opposition that there are many of us in government right now who feel that we are prepared to take up that cause.

Mr Reville: I didn't say that. He said that.

Ms Poole: He said that? Oh, there is even dissension within the ranks on this.

I would just like to close with those comments. Unlike Mr Reville and Mr Johnston, whose speeches in the House were excruciatingly long, I have made mine excruciatingly short. Thank you for your indulgence.

Mr Reville: It's never excruciating when it's short. It's wonderful when it's short.

The Chairman: Thank you, Ms Poole. I take it that Mrs LeBourdais wishes to reserve her comments for first thing tomorrow, and I have also Mr Carrothers, who may or not want to make a few comments after Mrs LeBourdais. Then we will get into the beginning of our clause-by-clause consideration.

There being nothing further for today, the committee stands adjourned until 10 o'clock tomorrow morning.

The committee adjourned at 1703.

LADON  
XC12  
-576

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

INDEPENDENT HEALTH FACILITIES ACT, 1989

TUESDAY 29 AUGUST 1989

Morning Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Eves, Ernie L. (Parry Sound PC) for Mr Jackson

LeBourdais, Linda (Etobicoke West L) for Ms Poole

McClelland, Carman (Brampton North L) for Mr Beer

Reville, David (Riverdale NDP) for Mr Allen

Clerk: Decker, Todd

Staff:

Spakowski, Mark, Legislative Counsel

Tucker, Sidney, Deputy Senior Legislative Counsel

Witnesses:

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriole L)

MacMillan, Dr Robert, Executive Director, Health Insurance Division

Spence, James M., Special Counsel to the Ministry of Health; with Tory, Tory,  
DesLauriers and Binnington

ERRATUM

S-19, page S-33, paragraph 4 should read:

I am somewhat concerned about a few other issues. One was the issue addressed by several health professionals of transferability of licences, profit versus nonprofit. I think that almost everybody would prefer to see nonprofit facilities providing these services where required. I suppose the point where I would disagree with my two friends to the right is that on some occasions I can see where the only way a particular service may be able to be provided is through a for-profit agency or facility. I suppose that is why the bill is drafted the way it is and I support that.

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 29 August 1989

The committee met at 1019 am in room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: The committee will come to order. The standing committee on social development is convened to deal with clause-by-clause consideration of Bill 147, an Act respecting Independent Health Facilities. Yesterday we traded amendments and general comments. I had one other speaker on the list. Before that, I notice the ministry has tabled a number of documents. Minister, did you wish to comment on the documents tabled with the committee?

Hon Mrs Caplan: No, I think they are self-explanatory. If there are any questions anyone has, we would be pleased to answer questions. We are prepared to go immediately to clause-by-clause.

Mr Reville: What is it we have here, this big pile of stuff?

Mrs O'Neill: Answers to questions.

Hon Mrs Caplan: These are written answers to some of the questions that were raised. There is a package of information that has been tabled with the committee. I can go through the list if you wish.

Mr Reville: I think it would be useful to have on the record the information the minister has provided.

Hon Mrs Caplan: This is information provided for the standing committee on social development. I think we will do them by issue rather than by number. The issue is information on quality assurance mechanisms in health care settings. Another one is from the estimates of 1990-91: estimated cost of administering the Independent Health Facilities Act. The third one is provision of information on services which are being performed in free-standing clinics. The next is information on proposed methods to evaluate the effectiveness of independent health facilities. The last one is information on radiology billings by physicians.

This is information that was requested by the committee from Ministry of Health staff and it is here provided and we are happy to answer questions. Dr MacMillan had a comment.

Dr MacMillan: As a result of yesterday's discussion about radiology, I made a commitment to provide more detailed information which is presently being prepared by my staff in Kingston and will be ready first thing tomorrow morning.



The Chairman: Are there any questions?

Mr Reville: I have one question and one comment, which I will be pleased to be short about. First of all, I want to thank the ministry for providing this information and I commend it to members of the committee. There are some significant bits of information here that the committee did not have previous to its deliberations, and it is very useful to have them. For instance, we see that the size of this program is estimated by 1991 to be about \$26.6 million a year, not an inconsiderable amount of money, unless you are dealing in a Health budget, which makes all those zeros spin around in your head.

One of the pieces of information that has not been provided, which was requested by my colleague Mr Johnston, related to an update on the split between for-profit and not-for-profit nursing homes. We had some information that took us up to about two years ago, when the select committee on the privatization of health care was doing its work. Mr Johnston had requested an update on that. I am wondering if the ministry would help us understand where that information has got to.

Dr MacMillan: I commented yesterday that I would have that for you this morning and I still will.

Mr Reville: He has an hour and 35 minutes to deliver on that. About five to 12, we will emit a small beep which will help you to—

Mr Eves: Will that be any different than the other beep?

Mr Reville: It may be hard to tell the difference between the beeps.

The Chairman: Mr Reville, you indicated you had some short comments.

Mr Reville: That is it.

The Chairman: Mr Johnston?

Mr R. F. Johnston: He raised my concern.

The Chairman: Mr Eves, any questions on the documents tabled?

Mr Eves: No.

The Chairman: Then we will go back to the speakers list I had yesterday. Mr Carrothers indicated he does not wish to comment at this time. Mrs LeBourdais, you are on.

Mrs LeBourdais: I just wanted to take a very brief opportunity to respond to Mr Johnston's comments of yesterday, in which I think he was to some degree lending support to the bill but with certain reservations, etc.

As a member of the committee, I just wanted to indicate that I was supportive of the bill because it was not procedure-specific, that it covered areas of sensitivity, such as abortion, mental health, AIDS, etc. I think you referred to pie in the sky or dreaming, as it were. I think we can look forward to a day where any of these procedures can be done in a health facility that does not have any stigma attached to it, so that one does not have to feel any of the social pressures of going into an AIDS clinic or an abortion clinic or one that deals with mental health, etc.

I also feel that the bill provides an appeal to cabinet so that there is not that all-foreboding power of a minister which seemed to be causing the member some particular concern. That makes it a landmark piece of legislation and I think builds in an element of protection.

I agree with my colleague who spoke yesterday, Dianne Poole, that those of us who are supportive of a particular pro-choice position are comfortable that this bill will address that as well as other sensitive issues.

Mr Reville: It does not take much to calm you down, does it?

Mrs LeBourdais: No.

The Chairman: Are there any other comments of a general nature by members of the committee? Then we will proceed with clause-by-clause consideration on the basis of our understanding yesterday that we will go through the clauses, discuss them, consider amendments but stack the votes until an at this point indeterminate time but no later than at the end of the bill.

Different ministers have different styles, but I am used to the parliamentary assistant or the minister taking us through clause-by-clause and, if you have the opportunity, either you or your backup people make some opening comments on each section in terms of its importance or its main thrust, why it is there, any points you want to make.

Beginning with clause 1, do you have any comments or do you wish your staff to make any comments before I go to other members of the committee?

Section 1:

Hon Mrs Caplan: There are a number of amendments to the first clause which have been tabled.

The Chairman: Yes, but before I call for amendments, you have an opportunity to make any general comments on section 1 if you wish.

Hon Mrs Caplan: This is the standard definition part of the act, where we try to be as clear as we can so that if there are any questions about what is meant by any term or phrase it is responded to in this section.

The Chairman: I have a number of amendments tabled with me on section 1 of the bill. Who would like to start?

Mr Eves: I am not going to belabour the point, but we had a discussion yesterday with the ministry's approach to amend sections 24b, 24c and 24d. That is how they wish to approach this problem. We do not believe that is a wide enough approach, if you will, so until we get to that section, I think I would be inclined to move the four amendments I had suggested to subsection 1(1). I will read them all one right after the other if you prefer. It will save some time, maybe.

The Chairman: You are moving them as one amendment?

Mr Eves: No. I am just going to do them all at once if that is possible. That will save some time.

The Chairman: Okay. We will vote on them individually, though.

Mr Eves moves that subsection 1(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out the definition of "college" and inserting in place thereof the following:

"'College' means the governing, registering or licensing body of a health profession."

Mr Eves moves that subsection 1(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out the definition of "health facility" and inserting in place thereof the following:

"'Health facility' means a place in which one or more members of the public receive insured health services and includes an independent health facility."

Mr Eves moves that subsection 1(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by inserting the definition of "practitioner" as follows:

"'Practitioner' means a person other than a physician who is lawfully entitled to render insured services in the place where they are rendered."

1030

Mr Eves moves that subsection 1(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out the definition of "registrar" and inserting in place thereof the following:

"'Registrar' means the chief administrative officer of the governing, registering or licensing body of a health profession."

The clerk advises that we can take them all as one amendment. Your comments on these, then, Mr Eves?

Mr Eves: We had this discussion yesterday, and just briefly, not to belabour the point, I would think that if we are going to—

Interjection.

The Chairman: I am sorry, I am getting a comment here. Is there a point?

Mr R. F. Johnston: If you are going to move from what is presented before us to saying they are going to be taken together, generally speaking that can be done, but I would have thought it required a motion to say we are going to do that and get that agreement rather than just to do it. Am I wrong?

The Chairman: Mr Eves moves that we treat the amendments to subsection 1(1) just read into the record as one amendment.

Mr Carrothers: That is an eminently reasonable motion.

The Chairman: Is there agreement on that?

Motion agreed to.

Mr. Eves: We would like to see the approach taken with the Independent Health Facilities Act to be a very broad one that will encompass other health professions and practitioners other than physicians. We would like that approach to be as broad as possible. Mr Sharpe, in response to that approach yesterday, said that at this point in time perhaps it would become more clear after the health professions legislation review is in place. The ministry and the government purport to take a more cautious approach, if you will, perhaps not as broad an approach—in my opinion, anyway—by not dealing with section 24a and proposing amendments to sections 24b, 24c and 24d. I prefer to stick by our original approach and that is why I am moving the amendment.

Mr Carrothers: As Mr Eves has pointed out, we did really have the discussion on this yesterday. As he is aware, there are amendments coming up to sections 24b, 24c and 24d which deal with this in what is felt to be a much more appropriate manner by those who have drafted this bill. To make amendments here and then to make amendments in section 24 would simply create legislation which has conflicts within its own drafting. For those reasons, I will not be able to support these motions.

The Chairman: Shall the amendment carry? Opposed?

Motion negatived.

Mr Reville: Some people are not awake over there.

Interjections.

The Chairman: Are there further amendments to section 1?

Mr Carrothers moves that subsection 1(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out the definition of "insured service" and inserting in place thereof the following:

"'Insured service' means

"(a) a service rendered by a physician for which an amount payable is prescribed by the regulations under the Health Insurance Act, or

"(b) a service prescribed as an insured service under the Health Insurance Act rendered by a practitioner within the meaning of that act."

Mr Carrothers: As discussed yesterday, this is a refinement of the definition of insured services which is presently in the proposed amendments to the act, allowing greater flexibility to deal with some of the nonmedical types of facility that we heard discussed during our hearings. This would just allow greater flexibility in making payments out of the health insurance fund.

The Chairman: Shall the amendment carry? All those in favour? Opposed?

Motion agreed to.

The Chairman: Mr Carrothers moves that subsection 1(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following definitions:



"'Medical care' means health care;

"'Medical record' means a record relating to health services;

"'Patient' means a person who receives health services in a health facility."

Mr Carrothers: Again, these are just additional definitions to add more precision and clarity to the legislation.

The Chairman: Any other comments?

Mr Reville: The only comment I would make in connection with the amendment is that I find these definitions to underscore the point I was making in my general remarks yesterday, that while the bill is touted as one that will enhance community-based care, it is so procedure-specific that I think it is really about medical procedures. These amendments confirm that in my mind, where a bill that talked about medical care is suddenly talking about medical care meaning health care, which I think is what you might call a dead giveaway. A dead giveaway may be a difficult concept for people to grasp. None the less, that is the best I can do.

The Chairman: Any further comments? Mr Carrothers.

Mr Carrothers: Perhaps just a brief one. I see it as being the complete reverse. Here we are defining medical care as meaning health care. I am not sure how much broader a concept it could be than health care. That seems to include all kinds of things, so—

Mr Reville: I agree with you that health care indeed is broader than medical care. I am suggesting that the necessity that you see to change a bill that talked about medical care to health care indicates that your motives are suspect, which you cannot talk about. I cannot talk about your motives; it would be unparliamentary.

Mr Carrothers: I appreciate that you did not.

Mr Reville: I would never.

The Chairman: Any further comments? Are we ready for a vote on the amendment? Shall the amendment carry? Carried.

Motion agreed to.

The Chairman: I do not have any further amendments before me for section 1.

Mr Reville: I have a warning to deliver to you, Mr Chairman. It is a friendly warning. "Facility fee" is a subject I may want to address later on, and it is one of the definitions herein.

The Chairman: That would come under section 1.

Mr Reville: It would be there under section 1.

The Chairman: So we may come back to that. Is there any further discussion on section 1 as amended? We have agreed to hold off the vote on each of these sections, so moving to section 2.

Section 2:

The Chairman: Minister, do you have any general comments on section 2?

Hon Mrs Caplan: Section 2 deals with the exceptions to the act. There are a few amendments to clarify in response to some of the representations that have been made.

The Chairman: Mr Carrothers moves that section 2 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by inserting before "places" in the second line the word "persons."

The Chairman: Discussion on that amendment? Shall the amendment carry? All those in favour? Opposed? It is carried.

Motion agreed to.

The Chairman: Mr Reville moves that subsection 2(2) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following:

"(iii) an office or place used for the purpose of providing chiropractic services."

Mr Reville: Chiropractors were concerned that the bill was not clear in indicating that the normal services they provide in their offices were not to be included in the bill. The ministry has responded by tabling one out of about 4,500 regulations which shows the classes of services that will be exempt, which includes, as subsection 1(b), chiropractors. This is a draft regulation. It is not gazetted; I assume the government intends to do that, but I have no way of knowing. I wanted greater specificity so I put it in the bill.

Mr Carrothers: I will be moving an amendment a little later clarifying the regulation-making power under this section. I would just suggest that there may be other types of medical care besides chiropractors, and by doing this in regulation and by confirming the regulatory powers as we intend to do, it provides a much more flexible way to deal with this. As has been indicated earlier, this legislation is landmark legislation and we need to allow the ability for that to grow with time. I think it is much better done under the regulation-making powers. So we will not be supporting this amendment.

1040

Mr Eves: I will support Mr Reville's amendment, although I would have much preferred to have a more encompassing list of health professionals that were exempted. I share Mr Reville's concern that we are going to have, I suspect, innumerable regulations under this piece of legislation. I believe that before the hearings even started and certainly when they started, some members of the committee expressed a desire to see the proposed draft regulations, and what we have is one little page with a list of seven proposed exemptions from this one specific section.

I will support Mr Reville's amendment, but I would have much preferred to have it more exacting and see the regulations under the act because a lot of things are going to be done by regulation under the act and, to date, this is all we have seen.

The Chairman: The minister wishes to comment on this amendment.

Hon Mrs Caplan: When the chiropractors and a number of other professional groups were here, the intent was clarified about those that are existing today. By dealing with exemptions in regulations, it allows for the opportunity that my colleague Mr Carrothers mentioned. Should a chiropractor or any of those who are on the exemption list under regulation wish to participate in the future, that would then be possible.

Including the exemption in this legislation forecloses opportunities which may present themselves in the future. From my discussions with professional groups and also with individual professionals, the best advice that I have received is that the flexibility of this bill is such that it will respond to changing times in the future. So I think it is most appropriate that we deal by regulation. The regulation which was distributed to members allows for new and emerging professions to be responded to appropriately as to their inclusion in or exclusion from this legislation.

The Chairman: Mr Reville, any concluding comments?

Mr Reville: No.

Motion negatived.

Mr Reville: On a point of order, Mr Chairman: I would now withdraw my amendment to subsection 26(4), which was companion to this lost motion. That saves the committee time later, just in the spirit of co-operation, good fellowship, peace, love and joy.

The Chairman: Thank you. I believe we have another government amendment.

Mr Carrothers moves that section 2 of this bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following paragraph, a paragraph to be numbered 5:

"A person who is or a class of persons that is exempt by the regulations."

Mr Carrothers: As I indicated, this perhaps is to confirm the regulation-making power and just clarify that regulations can be made as have been proposed, and as there is a suggested regulation circulated before the committee to deal with certain classes which are to be exempt from this legislation.

Mr Eves: Having lost the day on Mr Reville's amendment, I would be happy to support this.

Mr Reville: Mr Eves is exactly right. We will support it too.

Motion agreed to.

The Chairman: Is there any further discussion on section 2, as amended?

Mr R. F. Johnston: Yes. I would like to discuss a little bit with the minister, if I might, the presumptions under subsections 2(3) and 2(5) in terms of abortion facilities. You were not here yesterday when I raised my

concerns again about how this bill could potentially be used in a restrictive way around abortion.

I am wondering if you can enunciate for us today what action you are proposing to take as Minister of Health to make sure that it does not become used in a restrictive fashion, but that in fact access to services in independent facilities or hospitals or whatever across the province will be guaranteed to women.

One of my concerns is that if it is not, if I do not hear a plan from you about how that is going to be done in the next little while, then one of the things I would hope we might do would be to talk about exemption of those services from this particular plan at this point and have some other model established to try to make sure we get them in place.

I wonder if you could talk a little bit today about how it is that you are planning on making sure that these kinds of facilities, the "have" proposals, come forward in those areas like southwestern Ontario where there is a dearth of facilities at the moment or in other parts of the province that can be brought forward under this act or in some other way.

My concern is not with this as enabling legislation, as you know. My concern is that it could be restricting legislation in terms of this particular style of service, whether in a clinic dealing entirely dealing with those kinds of services or in a much larger clinic with a whole pile of other services being provided as well.

I am just wondering what you see as your role in guaranteeing that we are going to see that kind of coverage around the province of this kind of service which we do not have at the moment.

Hon Mrs Caplan: I am sorry that the member was not here when we had this discussion. I think it was the Carnelian Health Services Co-operative that was here when I talked about our approach to the provision of women's health services. As you know, this bill is not procedure-specific, nor is it service-specific. The Ministry of Health has an obligation to provide for all health services. Those obligations are defined very clearly under the obligations of the Canada Health Act.

Our approach to women's health services is the approach of comprehensive women's health services provided through women's health centres. What I said is that we have at this point in time been looking at the establishment of women's health centres and the provision of women's health services in a number of different ways. As the member knows, we established a women's health centre here in Toronto through the Women's College Hospital, and one as well through St Joseph's Health Centre. We established a women's health centre in Peterborough and we expanded and enhanced women's health services in Hamilton through Chedoke McMaster Hospitals.

We have been very clear that we would also like to see the provision of women's health services in a community-based approach. The opportunity that this bill provides is to allow us to expand all health and health-related services in a community-based approach where you have that kind of quality assurance, which really means that whatever services are being provided, they will be provided safely in the community. You presently have in-hospital the kind of quality assurance and utilization review that we believe should exist for any services traditionally provided in an in-hospital setting.



What we have also said about our approach to women's health services is that women's health is far more than just reproductive health. We want to make sure that as we deliver services, we determine what is available in the community and that, as part of a request for proposal, the services that the member has concern about are just one component of overall women's health services. Abortion services or abortion referral or the need for pre-counselling or post-counselling for women in need of that health service are just part of the overall approach to the delivery of comprehensive women's health services.

I would say to him that the approach of the ministry in delivering women's health services is really the same in delivering any needed health service. We want people to have equity of access to effective, quality health services as close to home as possible in a timely and sensitive manner. Whether that service is delivered in a hospital setting or a community setting, we want to be able to assure the public that it will be provided safely and in a quality-assured environment.

1050

Mr R. F. Johnston: I think nobody has any concern with there being women's health clinics or centres. Our party has had as a policy since 1981 that these be established. The problem is never around establishing the generic service but, as you will know, around the provision of the particular abortion or abortion referral services that have been so problematic in the last little while. My concern is still that I do not see as yet this sign of commitment in that area.

For instance, in the two clinics in Toronto that have been funded, St Joe's is definitely not going to be involved in abortion or abortion referral. I presume Women's College is, tied into its regular hospital performance. What about the Peterborough clinic?

Hon Mrs Caplan: It is my understanding, as we review what the needs are in individual communities, that the proposals that come forward include the kinds of services to respond to the special needs of the community. It is my understanding that abortion services are part of the services provided in the Peterborough centre, as they are in Hamilton.

But it should be noted that, as I say, women's health is far more than reproductive health and that there will be centres established which will provide other services. I do not think that it is appropriate to just—

Mr R. F. Johnston: But nobody has a problem—

Hon Mrs Caplan: —focus on that alone when you talk about women's health needs.

Mr R. F. Johnston: It is absolutely appropriate, because there is no problem with establishing a women's health centre that is not dealing with abortion. Those are easily established anywhere.

Mr Reville: Hardly anybody pickets them.

Mr R. F. Johnston: They very seldom get pickets at all. Exactly. The difficulty is if, in establishing some of these centres, we preclude the possibility of providing abortion services in that area.

Let me give you the example of Windsor, where it is my understanding that a hospital is presently looking into the notion of establishing a women's clinic, a hospital which made an agreement prior to this initiative with a Catholic hospital in that area that one of the things it would not do in taking over certain of the responsibilities of the Catholic hospital would be to perform abortions or do abortion referral. Therefore, in this southwestern Ontario area, which is underserved in terms of abortion referrals and abortion services specifically, there may very well be an institution get the health service which will provide your easy-to-deliver women's health services but will not deal with the issue of abortion.

What I am trying to come down to is that specific matter. You have chosen to go the generic route. It is not my bill; it is your bill. You have chosen to do that, and supposedly the abortion issue can be dealt with within that framework, according to what you have here.

The history of what has happened with abortion is just exactly the opposite, as we know through all the court battles that have gone on in the last little while. What I am looking for is some sort of notion of what your plan is to make sure that, within the generic system you want to use, the women's health clinics, no region of this province is going to be left without the facilities that provide abortions and abortion referral that are a woman's right.

Because it is the most sensitive of all the issues we can deal with and because it has been neglected so badly through the decades in the past, right up to this last month or so, I just want to know what your plan is to make sure that in a place like Windsor and places in the north, for instance, those facilities will be made available using this act, if you are going to do it, if this is your route, to make sure that in fact those proposals come forward and that those kinds of services are brought into place even if there is going to be controversy.

Hon Mrs Caplan: I think the most appropriate response to your concern is the request for proposal process. When the minister has identified a need for any service, whatever that service happens to be, as part of the request for proposal process the ministry can be quite specific in what services it is looking to provide in that community.

That happens now in discussions across the province on what services hospitals will be providing, but this provides an opportunity for us to identify a needed service, seek the advice of district health councils, which offer advice, and the obligation to assess those proposals on the basis of the delivery of program and needed services to people right across this province. There are always competing needs within the community and we see this bill as in fact not being either procedure- or service-specific but allowing the ministry to respond where a need has been identified.

Mr R. F. Johnston: I will let Mr Reville pursue this a little bit.

The Chairman: All right. Mr Reville, you are next.

Mr Reville: There is both a political and a substantive value to being nonspecific about the bill. The programmatic value is that this bill could then encompass any service that might be developed as time goes along and you do not have to change the bill; that is good. The political value is to protect the government from this being an abortion bill; I understand the interest the government might have in doing that.

What we have said in our comments about the limitations that we feel very strongly the district health councils have in terms of having the resources and perhaps the will to take on difficult issues like the abortion question is that we just do not believe we are going to see district health councils come forward with an assessment that says, "Minister, we need better abortion services in our region." We do not think the RFP—that is the request for proposals—is ever going to be generated because it will not get triggered. The district health councils will have plenty of other needs to assess in their community.

We do not find it particularly comforting that the Ministry of Health has an obligation to provide all health services. We know it does, but we can point to many areas where the fact of the matter is that the health services have not been provided. Head injuries is a good example. The Liberal caucus room was used recently by the Head Injury Association of Canada for some hearings. What we do provide is brilliant trauma work these days so that people who would have died do not die. Regrettably, because our rehab approach is lagging, some of the parents and the people wish they had died because they live this nether, Twilight Zone life for the rest of their lives; basically we have got zippo in this province in terms of rehab follow-up for people who have suffered traumatic head injury. The same might be said, although increasingly less so, about people who suffer from mental health problems.

Part of the problem is, what do we mean when we say health care? Do we mean an operation? Do we mean a pill? Do we mean some kind or other of pseudo-scientific therapy or even scientific therapy? Let's be generous in this regard. But do we also mean social and economic support? Increasingly, I think society has come to believe that we have to mean that.

I guess the question that is flowing out of this preamble is, will the minister undertake to require district health councils as an early priority to assess the availability of abortion services in their district and to make recommendations? Will that be an assignment to DHCs?

Hon Mrs Caplan: In fact, this bill gives to the minister the opportunity, notwithstanding the advice of district health councils, to go with a request for proposals where a need has been determined. Where for whatever reason that district health council has chosen to not give advice, or where there has been an identification of a need which has been brought directly to the attention of the ministry with or without the positive recommendation of the district health council, the minister can proceed with a request for proposals.

The role of the district health council is either to identify a need or, after a need has been identified, to advise the minister that this bill allows the minister to go with a request for proposals for any needed health service even if the advice of the district health council is to not proceed with that RFP. That is advisory, I understand.

1100

Mr Reville: That provides a perfect segue to my next question. You say you will not request district health councils to assess the availability of abortion services in their region. In that case, will the minister unveil her plans to ensure that abortion services are accessible to women in this province?

Hon Mrs Caplan: As the member knows, my predecessor established the



women's health bureau in the ministry and announced a program for the development of comprehensive women's health services in women's health centres. We went with the request for proposal to hospitals and responded, I think appropriately, with the development of some models in different parts of the province for the delivery of women's health services. We stated that our intention in the future is to look at community-based alternatives.

Our whole approach to women's health services is clear and on the record and we stand accountable during the estimates process, questions in the House and in this committee. This piece of legislation is just one tool that will allow us to establish community-based services in a quality-ensured environment.

I know the comments that have been made by the member, whose motives I do not question and I say that very clearly. To exempt any service from this bill will result in the proliferation of services in an environment where you do not have quality assurance in a manner which I do not believe is in the public interest.

Mr Reville: We have not asked that question yet; we will get to that in a minute. You are darned right, the minister and the government stand accountable and I think it stands condemned of not having done the job. The work that Marion Powell has done, I do not think has been achieved by the government; I really do not. The Women's College, St Joseph's, Peterborough and Chedoke efforts are a start, but we get a sense of drift in this connection. We think the issue is the kind of issue that the government would sooner not deal with on a priority basis and that is why women do not have access.

I also, quite frankly, just do not buy the rhetoric which the minister hangs on to for dear life that women's health is far more than reproductive health. That is true; of course that is true. It is one of those truisms, but it masks the problem that the tough issue has been, on one hand, abortion services and, on the other hand, free-standing birthing, for different reasons. My sense is that the politics of free-standing birthing are quite different. That basically has been a medical objection, which I see basically as a turf war and not as a tough, societal, moral question.

The moral question is a tough question; it is tough question for any government to deal with because it has its own members that differ and it knows that society differs, and it is quite convenient and tempting to kind of try to walk down the middle and say, "Women's health is far more than reproductive health," but where we are having the problem is not in providing women's health services—nobody would object to providing women's health services—when the objections come is when abortion services are provided. Let's not mince our words here.

I would submit that the reason there were problems in the Woman's Choice Health Clinic or the Choice in Health Clinic was precisely because the government was not prepared to fund free-standing abortion clinics because they had to rely on the financial clout of the professional to get the collective going. That is why that collective flew apart; it is because most members of the collective do not have the borrowing power that a physician has. If the government had said, "Yes, let's do this and put the money up," then we would not have the dispute between the Carnelian and Choice in Health.

I am absolutely certain about that, because I have had 20 years of experience in watching how collectives operate. Usually they fall on two



matters: one is financial liability and the other is professional and hierarchical kinds of stuff, which are very difficult to work with. If the minister is really interested in community-based approaches to women's health, then the government's money has got to be available to smooth out those professional-nonprofessional, built-in structural problems and to resolve the fact that some people can borrow money and some people cannot.

Dr Stein did not have any trouble at all getting an eye hospital going, because he is a physician and a bank would know what kind of flow-through that would be. But some social worker graduated from Ryerson who would be a wonderful counsellor is going to be laughed right out of the bank branch. If people do not believe that, drop into your bank branch and try to borrow some money to set up an abortion clinic—I do not think any of you are doctors—and just see how well you do. You will not do very well.

The reason we are raising this here is that this bill is going to result in the closure of the Colodny Clinic and is going to prevent the opening of the Toronto Birth Centre until such time as they may be successful in a proposal call. I think that is wrong. I hope I did not mince words here. Did you understand? Was that clear enough?

The Chairman: You were quite clear.

Mr R. F. Johnston: I want to pursue this a little further. You have been in government for four years now, during which time a number of major crises in the abortion issue have taken place in the courts, resolved in a uniform fashion by the Supreme Court of Canada. You have had time to identify the regions of the province which are underserved in this area. I presume, therefore, you have done that. Have you done that? As a minister, you have identified the areas in Ontario where access to abortion is limited; I presume you have already done that.

Hon Mrs Caplan: One of the things that we have as far as information available which was made public is concerned are all the hospitals that provide this service right across the province, but our approach as far as providing women's health services is concerned has been to develop a more comprehensive approach to women's health services and to see that those are provided in communities across the province.

I should say to the member as well—and this has been pointed out to me by a number of women right across the province, but particularly in some of the smaller communities—women in fact choose to have the anonymity of larger urban centres. That is one of the reasons that you tend to see concentrations in larger centres of some of the services where women, particularly when they are dealing their reproductive health, would prefer to have some services that they would prefer to travel for. You should know that.

Mr R. F. Johnston: There might even be some who prefer to leave Toronto and go to Owen Sound, frankly, the other way around.

Hon Mrs Caplan: I just wanted to raise that.

Mr R. F. Johnston: I understand the reality of that and especially in a society which is as highly charged around this issue as it has been. But the reverse is also true. If you had a comprehensive clinic established in Owen Sound which provided these kinds of services, there might very well be people from Mississauga who would rather go there than to go to a clinic in Mississauga for the same kinds of reasons, in reverse.

The point is that we know areas are underserved. You have had the chance for four years to identify them. You developed certain models, which are hospital-based at this point, which you have pursued and you know of the existence of three models in Toronto in the independent clinics at this point, and I still do not have any notion at all of what your plan is in terms of making sure that these services are available in various parts of the province.

I have not heard from you that you are going to be initiating a call in those areas where you have already identified this is a need to take that load off the district health council, to say to them, "You come in with your list of other independent facilities that you want with a range of other kinds of services, but we have identified"—it is very easy to do—"that this is a need in your area and we are putting forward the call for that now." You would take the load off them, you would take the political responsibility which is on all of us for that, and hopefully we would then get the access. Without hearing that from you, all I can see is that this is a restrictive bill. I still do not see that you have taken the action up to this point or that you are saying you are going to take the action which would guarantee that those kinds of services are going to be available in Haliburton and Timiskaming and other parts of the province.

Hon Mrs Caplan: I would be pleased to make available to the member a list of all the hospitals which provide all of those services—

Mr R. F. Johnston: I know them.

Hon Mrs Caplan: —particularly abortion services, across the province.

Mr R. F. Johnston: We know the percentage.

Hon Mrs Caplan: But I think it is important, when we are talking about this legislation, to again restate that this bill is neither procedure- nor service-specific and that it allows us to respond to the opportunities to provide services in alternative ways in a quality-ensured, safe environment in this community where those services are not available. That policy and that philosophy apply to a host of services which we presently today cannot respond to simply because we do not have a legislative framework that enables the expansion of community-based services.

1110

I would say to you that in the development of policy and in all of the interests of providing health services, this is but one tool to enable the orderly implementation of services in a community-based setting, which will allow us to respond not only to changing technology, new procedures, but in fact new and emerging professions, so that we can provide services which today are only available in an in-hospital setting. That is the intent of this legislation and I think to single out any one service, whether it is women's health services, eye surgery, options for community mental health services or any of those kinds of services today which, for whatever reason, because of the existing legislative framework can only be provided through a hospital, I think—

Mr R. F. Johnston: It is not true.

Hon Mrs Caplan: It is true. I can tell you the difficulty we had in looking at how we were going to provide services to Casey House; the fact that

it required an affiliation agreement with St Michael's Hospital.

Mr R. F. Johnston: No, no. Abortion services are being provided outside of hospitals now legally in Ontario and you know that. Whether or not you can change the regulations, not the law, is another matter.

The Chairman: Order.

Hon Mrs Caplan: We have before us a piece of legislation which will give us the framework for orderly planning, implementation, funding framework and, to me the most important aspect, quality assurance and safety to ensure the people of this province that with any services they receive outside of hospitals which formerly were provided only in hospitals, they can have the confidence that we have the kind of concern for safety in the community-based setting which we have taken for granted in the hospitals of this province. That is what this bill is about.

Mr R. F. Johnston: There are two things. One is that once you pass this bill this is the only mechanism that you have for doing that. It is not one of the mechanisms; it becomes the only mechanism for providing an independent facility to provide abortions, among other services, in Ontario. You surely will agree with that. That is now the only means you can do that.

Hon Mrs Caplan: At the present time there are services provided in three locations. One is in a hospital, two is in a physician's office. This will provide us with the third, which will be a free-standing, community-based facility. What distinguishes that facility from the physician's office is the requirement of overhead fees that allows the procedures which were traditionally done in hospital.

Physicians in their offices provide services today which are wide-ranging. This is but another tool to meet the changing technology that allows services which have traditionally been done in hospitals to be done in a setting which is not a doctor's office and not a hospital, but provides the same quality assurance and safety in a community-based setting outside of hospital. That is what this bill is about.

Mr R. F. Johnston: At the moment we know which hospitals provide abortions and we know that they have not changed dramatically in the last 10 years, which ones do them, except some of them have stopped doing them. We know it is a minority of hospitals in the province. We know whole regions of the province are not serviced by it. You now have under the law the capacity for a Morgentaler to be able to open a clinic. This bill, after it passes, will be the only means of a doctor or group of people coming together to try to establish a clinic at this stage. It is the only means that will be able to be done. We know the hospitals are not going to change their policies. We have already seen what has happened there. That is not changing dramatically anywhere in the province. If you want to have a clinic this is the only way you can do it now, under your act.

Hon Mrs Caplan: Or, in fact, we have community health centres, we have health service organizations, we are looking at comprehensive health organizations—all of which will be looking at service delivery in different models. What this does is give us the opportunity to provide services traditionally done in hospital and in fact in some cases enhance the role of community health centres and health service organizations to provide additional services that the present funding mechanism does not allow. Dr MacMillan was going to make a comment.



Dr MacMillan: I just want to clarify, so that Mr Johnston understands, because I think he is incorrect, the bill does not disallow abortions in doctors' offices. In fact—

Mr Reville: It disallows charging facility fees, Dr MacMillan.

Dr MacMillan: Can I just finish?

Mr Reville: No.

Dr MacMillan: There still well may be abortions done in doctors' offices right now in Ontario. The bill will allow for extra funding over and above the \$102 that is now provided for abortion, whether that abortion is done in the office or the hospital. After this bill passes, the \$102, or whatever we deem appropriate for that service, may still be added to the fee schedule so doctors still may be reimbursed for abortions in their offices through the Ontario schedule of benefits.

That can be doubled if the ministry decides to make abortions more available in ordinary doctors' offices throughout the province. So there are different ways. It does not restrict the doing of abortions simply by passage of the bill.

Mr R. F. Johnston: We are establishing this for quality control, we hear, and now we will be able to determine in these independent clinics just how good the service is. Now the rationale I am hearing for there being actual choice here is that doctors' offices, where there will be none of this kind of control, will still be an option at the \$102 rate.

I do not know; if that is the government's view of how abortion should be handled in Ontario—that rather than having it part of the comprehensive set of independent facilities around the province or women's clinics, that it should be handled in doctors' offices—that is a new policy that I had not understood was where this government was coming from on this.

What I still have not heard, and what bugs me about this whole thing, is this is enabling legislation. I agree it is enabling legislation. That means it is dependent on political will. I still have not heard anything which makes me feel any better at all about the fact that there is political will to make sure that the dearth of services out there is reversed.

I have not heard anything from you that you are going to plan to do that; that you recognize the problem there is going to be with the district health councils; that you already know the areas of the province where these kinds of services are necessary; that you have models that you want to be undertaken; and that you are encouraging people to do that through your initiative.

That is the kind of thing we want to hear because without it, all I can presume is that the will is not there, because if the will is there then you might as well state it and say, "I have this piece of legislation now I can use for this purpose and finally the appropriate funding can be made available to a clinic operating in that fashion, which I haven't been able to do in the past." That is another argument we can get into, but I am not hearing that. I am not hearing from you that you are committed to making sure that each region of this province has the services in this area that are required.

Instead, I hear you going back to the bafflegab about the generic



notions of the bill. No one disagrees with the generic notions of the bill, but if they are used to hide and mask a continued suppression of women's rights to access to abortion, that will be just a travesty if that takes place. All we are asking for—what I am trying to cut through in the language that I am hearing—is to get some notion that the political will is there. I am still not hearing that and I do not know why I am not hearing that.

Hon Mrs Caplan: Let me try once more just to give you a statement which perhaps, given the fact that I know the position you are taking, is not in any way assuming motive. As I said, I do not ascribe that at all. It is our intention to provide equity in access to all needed health services. When it comes to women's health services, our goal is to provide sensitive and timely access to all the health services that the women of this province need. That is our goal. It is also our goal to provide men with access to the services that they need. It is our goal to see that children have access to the services that they need. That is an overall goal of our health system.

We stand accountable, during the estimates process, on how we have responded to those needs. I know there will be opportunity for debate on an ongoing basis, but I want you to know of our commitment to provide for the health services for the people of this province and this is one of the tools that will allow us to do that in a community-based setting with the kind of quality assurance that we just do not have today.

1120

Mr Reville: One of the things I wanted to say again, to re-emphasize this—if I am incorrect, I really wish Dr MacMillan or the minister or Mr Sharpe will leap in and say, "You are wrong"—is that what this bill will make illegal, which is not today illegal, is the charging of a facility fee by a person who does not have a licence.

You cannot do an abortion for \$102. That is what the current Ontario health insurance plan rate is. It used to be \$100.30, I think, but it has gone up to \$102. That is what a physician gets paid if he or she does an abortion in a hospital. If you are from Milwaukee and you show up at Women's College Hospital to have an abortion, you are not charged \$102; you are charged at least a grand. That is the cost.

The physicians who may do these procedures in their offices can bill \$102 for the procedure. They might bill for an ultrasound, I suppose. They might bill for some counselling, but if that did not cover their cost, they are not likely to do it and they are not likely to put on the array of staff—a social worker, a psychologist, a nutritionist, whatever. A lot of women seeking abortions have health problems. They are suffering from malnutrition and other conditions that relate to pregnancy when somebody is not in the best of health.

Basically what this bill will say is that if X clinic is providing abortion services and has made a determination that a facility fee of \$175, \$200 or even \$500 must be charged in order to put on the service, it will be shut down. They will be breaking the law and they will be liable to the full force and effect of the penalties herein. That is the extraordinary part.

If, for instance, Dr Morgentaler cannot make a deal with the government and he says, "I have to have X," and the government says, "No, you have to have X minus two," then X minus two is the deal and the service may not be considered to be worth it for those practitioners to provide it.

I do not think I am misreading the law in this case; I think the law says that. Sure, Dr Colodny can continue to operate if she does not charge anything more than OHIP will pay her, but I sure as hell do not think that will be the kind of service we want to provide for people. I think we want to provide a comprehensive service where precounselling and post-counselling is as good as it can possibly be and that is where more money is going to be required. That is the problem I have with this.

Nobody in his right mind would not approve of efforts to create quality control and to ensure that public moneys are being effectively spent. Obviously, we do not want to enrich people unnecessarily; we do not want to nickel and dime them either. We want to provide a good service at the right cost.

Because of the nonspecific nature of this bill and the reluctance of the minister to make it clear in very clear terms that access is going to be provided in this province, surely you understand why Mr Johnston and I feel so uncomfortable about the bill, particularly as it relates to reproductive rights. That is it.

The Chairman: Are there any other comments on section 2? Moving along then to section 3, Minister, do you have any opening comments?

Hon Mrs Caplan: No comments.

The Chairman: Anyone else have comments on section 3? Moving along to section 4? Section 5? Does the minister have any comments on section 5?

Hon Mrs Caplan: No comments.

Section 6:

Mr Reville: I have one on subsection 6(3). I have an amendment, but I have a general comment to make about subsection 6(3), which I will make eventually. This is the preferential clause that has had some discussion both in debate in the House and here in the committee. This was the bold free trade stroke of the government, I seem to recall. I would like to ask, because we have not discussed this, why the ministry thinks it is necessary to allow for-profit proposals at all. Why not restrict it to nonprofit?

Dr MacMillan: First of all, in the grandfathering, as you recall from my briefing, our projected and estimated number of facilities that may be eligible for grandfathering number about 20 and there may be more as further information comes to us. In all of those, they are not presently constituted as not for profit. So that is one reason.

The second reason, I suppose, and I think you yourself have said it, is that in the far north and certain other areas of the province, it is possible that we would not be able to start up initiatives unless we had the support of some for-profit sectors. As a recent example, some laboratories were in difficulty in the north in hospitals. Recently, in spite of every effort, we have finally been able to get the assistance of a private corporation to assist in bringing that problem to resolution.

Recognizing that there is expansion in the bill that will allow now for more opportunities for community-based groups, when the bill was originally envisaged and for a great portion of the bill, it still will be medical services, even though there will be opportunities now for other professions.

In most medical services now where the option is a fee-for-service environment or the stimulus to come towards this type of activity, we would probably have no takers, certainly in the medical field, if we had to stipulate in some way a very restrictive not for profit. That is the best I can answer.

Mr Reville: I do not find that explanation unpersuasive, but I am concerned that the bill as it is written would allow a for-profit operation in areas that are not difficult to serve as well. So if a request for proposal came forward and there were no bids by a not-for-profit operation, then there would not be any preference to exercise.

I am wondering if I can get a comment from the ministry about how to achieve the goal that has been stated, which is to ensure that in those hard-to-serve areas, a facility will not be prevented from establishing merely because it is a for-profit facility. Could we not add something that says just what you said?

1130

Dr MacMillan: If I can answer for the ministry, I think Gilbert Sharpe will have an amendment with regard to the availability of capital cost that was missing from our original bill. I think that has been one of the main roadblocks in the development of community-based initiatives. I have some experience in that regard, having been in charge of the community health centres and health service organizations for two years when they fought for several years, successfully, to obtain capital funding, which is always their greatest impediment. There is no shortage of good people from the community coming forth with good ideas. I am sure Mr Reville knows that.

Mr Reville: I know many of the people.

Dr MacMillan: Where there is an opportunity for capital funding now, if the amendment proposed passes, I think that will be the greatest boost towards the not-for-profit people to come out of the woodwork. I think we will see an opportunity there that will go far beyond any other type of changing of this particular section of the act.

Mrs O'Neill: I would just like to say that I think that has been the stumbling block to the smaller groups and certainly the community-based groups. As far as the phrase "nonprofit" or "not-for-profit" goes, that can always be interpreted either one way or another, depending on what salaries people expect to get out of wherever they are setting up such an establishment, and what one person thinks is a livable salary and what another person does not. It is often very different. It is also very different what the community expects the person who is running such a facility to be paid for doing so. The administrative costs can always be either underscored or overscored.

To try to state in a bill what a nonprofit is is certainly not nearly as helpful as what we are doing here, which is encouraging people who may not, as Mr Reville said earlier this morning, be able to get the proper bank loan or have access to the kind of equipment they need to have very good, accountable care.

I feel the amendment we are going to bring forward on this issue is going to be the one that will attend best to the needs of nonprofit groups.

The Chairman: I have a question, Dr MacMillan. When you made

reference to an amendment, were you referring to one that was tabled yesterday or another one that is coming?

Interjection.

The Chairman: The one that was tabled yesterday.

Dr MacMillan: Yes.

The Chairman: I thought that was the case.

Mr Reville: As it happens, I do have an amendment that speaks directly to what Mrs O'Neill was just addressing.

The Chairman: Are you moving your amendment?

Mr Reville: I am going to move it now.

The Chairman: Mr Reville moves that section 6 of the bill be amended by adding thereto the following subsection:

"3a For the purpose of clause 3(a), an independent health facility is operated on a nonprofit basis if the profit derived from the operation of the facility is used exclusively in the further operation of the facility and no part of the profit is payable to, or is otherwise available for, the personal benefit of any person."

Mr Reville: What I think this amendment does is that it clarifies just the confusion that was raised by Mrs O'Neill about how you decide whether it is a nonprofit or not. This is independent of whether somebody is getting \$82,300 a year, \$41,500 a year or even \$18,000 a year. If there is money left over after the expenses, including salaries, are paid, that money then goes back into the operation. That is what we mean by a nonprofit.

Because Mr Spence is still here, if you have any questions about the corporate law aspect of it, you might want to direct them to Mr Spence. Maybe I will direct a question. Mr Spence, do you think that would do the trick for our purposes, to sort out what we mean by a nonprofit?

Mr Spence: I believe the section does what Mr Reville says it does. It says and it accomplishes that where there are profits left over, they are to be devoted to the operation of the facility.

Mr Reville: Those are all of my remarks. I think it is pretty simple.

The Chairman: Other people have indicated a wish to speak on your amendment, Mr Reville.

Mr Eves: I have no problem with Mr Reville's amendment. I think it clarifies what is or is not a nonprofit facility and I think it would be helpful.

Mr Carrothers: Perhaps I could just say the same. I think it does clarify what is meant by nonprofit and does not cause me any difficulty either.

1130

Mrs O'Neill: I must be having a lot of trouble with the word



"clarification" this morning, because I do not see how this can clarify it. In my mind, we would have a bureaucracy develop that would have to do this kind of work and inspection. Who is going to determine what you have put here? You are not saying a thing about the implementation of this.

Mr Reville: On the contrary, if you look at one of the documents that was tabled this morning by the ministry, there is a bureaucracy contemplated to administer the legislation. Any proposal that came forward would be costed out before it was approved. The ministry would have an opportunity to review those items that were listed as expenditures, including salaries if there were salaries or other kinds of remuneration. It might be fee for service, it might not, so that in fact a proposal could indicate that there would be a 10 per cent profit. It might indicate what would happen to that profit.

If the profit were to be paid to shareholders, then we would say this was a for-profit operation. If it were put back into the operation to enhance services, reduce the liability of government or expand services, but would not accrue to the benefit of any of the participants in the process, then that is what a nonprofit operation would be.

Mrs O'Neill: That is somewhat helpful. You are talking about the after-proposal—when this facility is established. The documents passed out this morning by the ministry, as I understand them, are in the proposal stage. So there is some level of inspection or auditing of the books or whatever on an annual or semiannual basis that your motion refers to. Do I have that correct?

Mr Reville: The government has indicated that yes, there will be a modest bureaucracy to monitor the operation, not only to check for quality but to check accountability, just like in an audit. That will happen. I think that about \$500,000 a year will do that. Before anybody gets a licence, the information they provide will drop them into one slot or the other. It would be either profit or nonprofit and this helps, I think.

The Chairman: Are we ready for the question? Shall Mr Reville's amendment carry?

Motion agreed to.

The Chairman: I do not have any further amendments tabled with me for section 6. Any discussion on section 6, as amended?

Section 7:

The Chairman: Does the minister have any comments on section 7?

Hon Mrs Caplan: These are the grandfathering provisions.

Mr Reville: Maybe we can start it. I have two amendments that I want to make to section 7, one of which I have a draft of, but it is not ready to give you yet and another that I am just making up in my head.

Mrs O'Neill: That is dangerous.

Mr Reville: There is no question that it is dangerous. Lawyers have earned a great deal of money trying to explain to each other what amendments that have been made up in peoples' heads might mean. I have been responsible

for a couple of them, I must say, in the minority period where we made legislation on the fly in the House. You should never do that. It is wrong.

Mr Carrothers: Can I quote you?

Mr Reville: Absolutely. There is an old saw that says there are two things you should never watch being made, sausage and laws. There may be other things, however.

Mrs Cunningham: You thought that one up on the fly, did you not?

Mr Reville: No. I am sure lots of people must know that.

Mr R. F. Johnston: I have heard that one from you.

Mrs Cunningham: That was not on the fly. That was carefully thought out.

Mr Reville: That is right. Most of the things I say that appear to be on the fly have indeed been thought out carefully. They may have been thought out by a person who suffers from a thought disorder.

Subsection 7(1) is the transitional grandfathering clause; we still have not been able to deal with the nongender way of describing this.

Mr Carrothers: Grandpersoning.

Mr Reville: "Grandpersoning" really sounds dopey.

Hon Mrs Caplan: How about "grandmothering"?

1140

Mr Reville: We could say "grandmother" for about 500 years—

Mr R. F. Johnston: So it evens out.

Mr Reville: Right.

Mr R. F. Johnston: That would be longer; grandmothers last longer.

Mr Reville: Let me just make the speech and I will be revisiting this. Under section 2, Mr Johnston and I fulminated at some length about our concern for abortion services and the feelings we have that this bill may in fact be disabling. Even though if read without adding any interpretation it appears to be enabling, in fact it could operate to be disabling, and that is our concern.

The other way to deal with this problem is to monkey with the grandfather clause. I understand the rationale behind the government's choosing the particular date that it chose. It is a time-honoured practice that when you introduce a piece of legislation that it gives notice to those people whom it will affect that something is emerging which may have an impact on them. It provides a period of grace in which people who have operated under a different set of rules can adjust themselves to a new set of rules. That is fair and just and it speaks to some fairly time-honoured principles of natural justice.

In my questioning of ministry officials, I have been able to discover that they believe, as do I, that there is only one facility that we believe might be an independent health facility that is operating today that is not captured by the grandfather clause, that the other 20, a list of which we have, were indeed operating prior to 2 June 1988 and that they will have the opportunity to continue operating and apply for a licence in due course. If they are licensed, fair enough; if they are not, too bad.

Of course, I am speaking about the Choice in Health Clinic which did not in fact come into operation until after 2 June 1988 and there is an explanation of why that happened. I do not believe this is a question of the collective or Dr Colodny saying: "I dare you to stop me." I think the situation that pertained here in Canada following the 26 January decision of the Supreme Court of Canada and prior to that created an uncertainty that made putting together the capital and the personnel to undertake an operation of this kind problematic.

Ladies and gentlemen, basically what I am leading up to is that I want to change the grandfather clause so that the Choice in Health Clinic can continue to operate. I do this with some reluctance because I do not know whether there might be out there something that will also be caught by the grandfather clause that we would not be as pleased about. So this a problem. I do not think I have any other choice, given the lack of comfort I have received from the ministry in terms of policy direction.

What I give notice of now is that I will this afternoon produce an amendment that says either one of two things or perhaps both. One is a fallback and one is not. One would say "proclamation" and the other would say "January 1, 1989."

There may be a procedural way to approach this. I do not know that this is an amendment that is very complex, although it does suffer from the problems I have already acknowledged. I thought about other ways to do this. I thought of specifying--the two operations I am most concerned about are Toronto Birth Centre Inc and Choice in Health and one of the approaches that I did discuss with the minister was to specify those two operations by name and try to put them in the legislation. That is not very neat and tidy because no other operation is mentioned by name and I do not want to make the nice, neat bill messy, but when you have a political agenda, as we do, which you cannot achieve in any other way, then maybe you have to put up with a bit of messiness. I may come back to that.

The other way to deal with it is to change the grandfather date. I wish there was a way to do it otherwise, but I have not found the ministry helpful in this regard. I do not think I have any other choice.

I do not have any further comments at this time, except to let you know that I will prepare the amendment and introduce it in the afternoon.

The Chairman: Mr Reville has given notice of two amendments to section 7.

Mr Reville: It is kind of a fallback, is it not? The proclamation does some things for me that are different than the 1 January date. It is also a bigger risk, it seems to me, for us all because all sorts of boys and girls might start dreaming up wonderful things and get them going.

The Chairman: Any further comments on section 7? Moving along to section 8.

Mr Reville: No. I am sorry. There is a large matter, which I do not know whether we want to get into right now—

The Chairman: On section 7?

Mr Reville: Yes. If I may raise it, just introduce it, there is a document before you provided by the ministry.

Interjection.

Mr Reville: No, but it is the document which I think is germane to a possible amendment on section 7. It is titled Issue: Information on Radiology Billings by Physicians. This is the material that I had requested Dr MacMillan to provide and it is provided. Maybe if I just briefly address, people may want to take a longer look at this in their lunch hour. You may know—and I raised this matter yesterday. The minister was not here, but we did have a small discussion about this, minister—that one of the things that has happened in Ontario over the last few years, and you can see this if you look at graph 1 where we have a line chart that shows the increase in the billings for ultrasound and radiology here in Ontario. In 1985-86, we were at \$64.2 million and in 1987-88 we were at \$80.6 million in amounts of money that the taxpayers of Ontario are paying for diagnostic radiology services.

There are 304 private radiology groups now registered and attached are some mysterious numbers, which Dr MacMillan could explain. There are 12 clinics that are \$1-million-plus operations. As I understand it, they do about one fifth of the business. What that means is somewhat over 290 do 80 per cent and a few very big radiology operations do 20 per cent, and they have had what you might call a land office increase; in one year a 24.4 per cent increase.

The other thing that is interesting to me is that if you look at the proportion of expenditure between the professional and technical fee, the T fee as we have come to know and love it, is 71 per cent and 28 per cent compensates professionals for their skill and learning. A huge amount goes for the cost of film and depreciation on ever-increasingly sophisticated equipment.

This is an issue about which the Ontario Hospital Association is very concerned because in order to run a hospital they are required to maintain a 24-hour radiology service. Private radiology services that are springing up very near hospitals are skimming off business, which means that hospitals are not being as cost-efficient as they could be if this were not the case.

1150

I would like to move an amendment that will allow better oversight of this kind of operation, better quality control and an opportunity for government to take a look at utilization. My concern is that we may be experiencing unnecessary utilization of very expensive health services, which are not in fact achieving a higher health status for people, but are merely performing services for which we are paying and which, if we had better quality control and better utilization review, we would do not do and we could therefore spend the money on something more useful.

This is an area that is complicated. It will involve the Health Insurance Act. I want to make sure that the amendment is going to achieve the result that I think is desirable, but I did want to raise the matter now to see if Dr MacMillan wanted to make any comments and wanted to explain this



document that he has provided. I offer this in the spirit of trying to ensure that our health care dollars are spent in the most useful way possible while being fair to those people who are already in this business.

Dr MacMillan: I indicated earlier that Mr Reville had before him a brief document because this was based on earlier information, but when we more seriously addressed the issue yesterday, I promised as quickly as my staff can gather it together a more detailed document. I think this is one of the most potentially explosive or controversial amendments that anybody is proposing. While I am very understanding of the position the hospital has taken and my bureaucratic responsibility is to be concerned with the distribution of health care dollars for professional services, it is not a move that you want to make lightly without a lot of assessment and discussion.

In addition to having time to look at the proposed motion for the committee and the additional information, I will get to you hopefully by this afternoon or later this afternoon, I wonder if you could not defer this amendment till tomorrow when people have had time to talk about it and study it and look at the information.

Mr Reville: On that point, Mr Chairman, I am prepared to provide an amendment early this afternoon, which people can take away with them and study. Maybe we could revisit this tomorrow. I also want to note that my beeper has gone off and the nursing home information is now due.

The Chairman: The procedure that the committee agreed to yesterday would permit what you suggest to occur.

Mr Reville: Oh, look. Here it is. Oh, just in time.

Interjections.

Mr Reville: Wait a minute. It says confidential on it. We cannot look at this.

Hon Mrs Caplan: The information is being gathered. We were attempting to see that it is before the committee. We had hoped to have it before noon. It will be here this afternoon.

Mr Reville: I wonder if this is an appropriate time to adjourn and ruminate over the lunch hour on what the right thing to do would be.

The Chairman: I do not see anyone objecting to your suggestion. So the committee stands adjourned until two.

The committee recessed at 1155.

# HANSARD REPORTING SERVICE

Room 481, Legislative Building, Queen's Park, Toronto, M7A 1A2

Telephone (416) 965-1456

Index Inquiries: (416) 965-2159

Editor of Debates: Peter Brannan

Deputy Editor of Debates: Ernie Hemphill

Editors: Don Cameron, Chief; Alex Jenkins, Deputy Chief; Edward Patrick, Supervisor; Pierre-André Beauchamp; Karen Bennett; Liese Binnie; Kathryn Blackett; Lawrence Bruner; Drummond Burgess; Deborah Caruso; Anne Lynas; Wendy Mills-Descheneau; Steven Smal; Janice Spellerberg; Tom Volk; Sheila Wawanash

Reporters (Tape): Kit Anderson-Knight, Administrator; Margaret Elkins, Wilda Ferguson, Supervisors; Jean Andrews; Sandra Arrizza; Peggy Brooks; Carolyn Brown; Sharon Chalupiak; Danica Dolenc; Margaret Grobicka; Richard Hilson; Barbara Milnes; Sonia Nesbitt; Chantal Perron; Margaret Prince; Mary Sutton

Reporters (Shorthand): Pat Girouard; Beth Grahame; Carol McIntosh; Maureen Murphy

Reference: Patricia Tolmie, Co-ordinator; Teresa Hamilton; Lynda Middleton

Index: Elise Sloga, Chief; Estelita Chan

Editorial Assistants/Printer: Corrine Marnoch; David Woodruff; Eamon Kade

Secretaries/Receptionists: Ethel Allan; Norma Thompson

Messenger: Stephen Marshall



CAZON  
XC12  
-S78

STANDING COMMITTEE ON SOCIAL DEVELOPMENT  
INDEPENDENT HEALTH FACILITIES ACT, 1989  
TUESDAY 29 AUGUST 1989  
Afternoon Sitting





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Eves, Ernie L. (Parry Sound PC) for Mr Jackson

LeBourdais, Linda (Etobicoke West L) for Ms Poole

McClelland, Carman (Brampton North L) for Mr Beer

Reville, David (Riverdale NDP) for Mr Allen

Clerk: Decker, Todd

Staff:

Spakowski, Mark, Legislative Counsel

Tucker, Sidney, Deputy Senior Legislative Counsel

Witnesses:

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriole L)

MacMillan, Dr Robert, Executive Director, Health Insurance Division

Spence, James M., Special Counsel to the Ministry of Health; with Tory, Tory,  
DesLauriers and Binnington

Sharpe, Gilbert, Director, Legal Services Branch

LEGISLATIVE ASSEMBLY OF ONTARIO  
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 29 August 1989

The committee resumed at 1424 in committee room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

The Chairman: We will call the meeting to order. Mr Johnston?

Mr R. F. Johnston: I have a matter of procedure. I hear from that senior ministry staff that they are a little concerned about the restrictions on apparel here, so I have been asked to move a motion that no member of ministry staff should have to come more formally attired than the member for Scarborough West.

Mr Reville: Would you care to speak to your motion?

Mr Carrothers: I am wondering, Mr Chairman, if that is in order. We seem to be dealing as a committee with things outside the purview of the committee.

Mr R. F. Johnston: Matters of procedure are always in order. I will not put it as a motion, but I did want you to be aware that this request from staff had been made and I thought it was eminently sensible that at the end of the summer we should still pretend that it is here.

Mrs O'Neill: Will they be consulting with you each morning?

Mr R. F. Johnston: No, but they should get ready for continuing. The longer we are here, the further and further the dress will deteriorate.

Mr Reville: It might make sense for everybody to get dressed together.

The Chairman: I am really glad you raised this because I keep learning new things in this job, and the clerk just informed me that the chair of the committee is the ultimate arbiter of decorum.

Mr R. F. Johnston: Ah. Thank God you are in the chair and not me.

The Chairman: Since I have not thrown you out yet, I had better be consistent.

Mr Reville: When Mr Johnston was in the chair, you should have seen the way the committee looked.

Mr R. F. Johnston: I did my best. Sorry.

Mr Reville: I hate to interrupt this to move an amendment to this bill now.

The Chairman: Before you start moving amendments, I want to bring to the committee's attention some things, to just mention that the clerk has made available for you a letter from the Ontario Public Health Association, a distribution—perhaps the minister may want to comment on it—and the clerk's official list of exhibits.

Hon Mrs Caplan: This is the five-to-12 document. It is expected at five minutes to 12.

The Chairman: And three New Democratic Party motions which the clerk has distributed and are in front of you.

Mr R. F. Johnston: Can I just ask a question first, to start off?

On the nursing homes information that was provided to us, my thanks. It is very useful to see that we have six new nonprofit homes in the last several years and that we are expecting more. It used to be that some of the homes that were normally not for profit were managed by for-profit nursing home chains. I could think of one in northern Ontario.

I wondered if anybody here was able to tell us if any of these homes included are like that of the Harold and Grace Baker Centre at Northwestern General Hospital which is managed by Versa-Care Ltd and where there are those kind of management contracts for supposed nonprofit care operations.

Hon Mrs Caplan: I cannot give you that answer.

The Chairman: Dr MacMillan?

Dr MacMillan: No. I am not in charge of the nursing homes branch. I need supplementary information, I guess, which we could get for the member or have someone here from the nursing homes branch.

Mr R. F. Johnston: I was just interested anecdotally; the information is useful.

The Chairman: That is the information distributed.

We were dealing with section 7 and, Mr Reville, you indicated that you wished to move an amendment.

Mr Reville: I am going to move an amendment, but curiously enough, if people look at the nursing homes list, we go back to 1988 where 93 per cent of the industry was for profit. That amounted to a government expenditure of \$367.4 million, and that ain't chopped liver. Yes, I have an amendment as predicted. In fact, I have two amendments to the same section in the final fallback principle and I will move the initial one.

The Chairman: Mr Reville moves that subsection 7(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out the words "2nd day of June, 1988" and inserting in lieu thereof the words "day the bill receives royal assent."

Mr Reville: I have not actually had the amendment reviewed by the legislative counsel, but it seems simple enough so that perhaps even I could move an amendment like that. It is okay, is it? Fair enough. You have heard my reasons for this so I do not need to go on at length.

What this amendment would do would be to take care of the Choice in

Health Clinic which has been operating since, I think, late 1988, and if the Toronto Birth Centre Inc got into operation would take care of it as well. It has the disadvantage of taking care of anybody else who happens to get going between now and royal assent. However, I move that motion. Royal assent is the day that many bills come into effect, as you may know, and I have changed that from proclamation because that is a less easily defined time. I took advice from members of the committee over the lunch hour. I move that and do not need to belabour the point.

The Chairman: Mr Eves, your comments.

Mr Eves: As used to supporting Mr Reville as I am, I am going to change here a little bit.

Mr R. F. Johnston: Bad lunch.

1430

Mr Eves: I sympathize with the position that he has taken; however, I think this amendment may have the unwanted consequence of allowing in some of the other facilities that are operating under the same amendment. I also would not mind hearing from the ministry about what its intentions are with respect to the two centres in particular that Mr Reville has alluded to because perhaps there is some way that they could be accommodated other than being grandfathered, such as a request for proposal.

Hon Mrs Caplan: The two centres that were referred to were Dr Colodny's centre and the Toronto Birth Centre proposal. At the present time, the requirement under the bill would require a determination of need. That could be determined either by the ministry or through consultation with the district health council. Following that determination, a request for proposal would be issued and Dr Colodny and anyone else who wanted to reply to a request for proposal for the provision of women's health services would have the opportunity and their proposal would be judged on the basis of their merit.

It should be noted that Dr Colodny is a physician, and following the passage of this act would not be able to charge a facility fee but could continue with the practice of medicine in her office and would not be impacted by this legislation unless she formally charged a fee. But in order to be licensed under this act, since she was not in operation on 2 June 1988, she would have to reply to a request for proposal if one were issued.

The second one, the Toronto Birth Centre, is not in operation. The statement that I made was that the first request for proposal following proclamation of this act would be for three pilot birthing centres licensed under the Independent Health Facilities Act. The change of policy to allow for out-of-hospital birthing centres—and as you know, we have four pilot birthing centres which are in-hospital and hospital affiliated, one in Port Arthur in Thunder Bay, Riverside in Ottawa, Peel Memorial Hospital in Brampton and Scarborough Grace Hospital. They were approved almost a year ago now. This would be for three pilot sites licensed under the Independent Health Facilities Act, and the reason for that policy is because we could have a safe environment and ensure the backup, support and the quality assurance which presently is only available in hospital.

The intention is to go with a request for proposal as soon as possible following proclamation of this act, and anyone wishing to establish a birthing centre could apply. Without prejudicing in any way the outcome of the



response, I do not see any reason at this point in time why the Toronto Birth Centre would not want to reply to a request for proposal.

Mr Carrothers: Mr Reville has indicated himself that there is a bit of a downside to this amendment. I think that is more than a bit of a downside. By using the date of royal assent, I think you would be creating a licence to open a facility and get grandfathered and I think you would create an explosion. I think we need to stay with the original date that this bill was tabled for the House and I could not support this amendment.

Mr R. F. Johnston: I just wondered how it was that the ministry knew it was going to ask for proposal calls for birth centres when it still had no idea where it was going to move in terms of access to abortion clinics.

Hon Mrs Caplan: We had some discussion earlier this morning about our policy. As I mentioned before, we had moved with proposal calls for in-hospital women's health centres and have said that at some point in the future we intend to look for community-based proposals. I cannot give you the time line on that. We have announced that the first proposal call under this bill will be for the birthing centre.

Mr R. F. Johnston: Exactly.

Hon Mrs Caplan: On this basis of determination of need, the request for proposal would follow that kind of examination.

Mr R. F. Johnston: Again it comes down to the political will and we are beginning to see a little more clearly where that lies.

The Chairman: Is there any further discussion? Mr Reville, do you have any concluding comments on your motion?

Mr Reville: Put the question, Mr Chairman.

The Chairman: Okay. Shall the amendment carry? All those in favour of Mr Reville's amendment? All those opposed?

Motion negatived.

The Chairman: Your second amendment?

Mr Reville: My second amendment deals with the concern raised by both Mr Carrothers and Mr Eves, because it replaces the date 2 June 1988 with the date 1 January 1989. I have to move it, of course.

The Chairman: Mr Reville moves that subsection 7(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out the words "2nd day of June, 1988" and inserting in lieu thereof the words "1st day of January, 1989."

Mr Reville: Speaking to it, the reasons are the same, although this would cover only the Choice in Health Clinic. The information I have been able to glean from the ministry is that there are no other independent health facilities that would be caught by this amendment. That sounds pretty compelling to me and I expect all to support this one.

The Chairman: Comments?

Mr Reville: Should I have said that? That sounds a little silly, doesn't it?

Mr R. F. Johnston: Don't worry about it.

The Chairman: Are you ready for the question then?

Mrs Cunningham: Could I ask a question?

The Chairman: Certainly.

Mrs Cunningham: It is regarding the statement that was just made. Do we know for sure? Is there any way, before we finish these hearings, that we can know for sure?

Hon Mrs Caplan: The only way we know for sure what independent health facilities may be operating at the present time is by those who have contacted the ministry and expressed an interest to this time.

If you will recall, when we first tabled this bill we estimated that eight to 10 such facilities were qualified for grandfathering. Our estimate is now approximately 20. The truth is that we would have no definitive way of knowing at this point exactly what the number is.

Mr Reville: If I may, I do not want to interrupt, Mrs Cunningham.

Mrs Cunningham: No, no.

Mr Reville: I very specifically asked the ministry if it knew of any other and it said it did not know.

Hon Mrs Caplan: That is correct.

Mr Reville: That does not mean there are not any. I do not know of any. The ministry says it does not know of any.

Hon Mrs Caplan: We do not know.

Mr Reville: There may be some but, as far as I know, there is one and that is Dr Colodny's Choice in Health Clinic.

The Chairman: All those in favour of Mr Reville's amendment? All those opposed?

Motion negatived.

The Chairman: Mr Reville, you have a third section.

Mr Reville: This amendment, however, is quite different, but it does not come until the end of the section, so why do we not see what is going to happen to the middle of the section first?

The Chairman: Are there amendments to the middle?

Mr Reville: There are government amendments that have already been put. We have deemed that they are put. There is motion 12, for instance.

The Chairman: We do not vote on those.

Mr Reville: I do not have any comments on any of the others.

The Chairman: I think your third amendment would be in order now.

Mr Reville: The third amendment is relating to the matter I raised yesterday and again this morning, to give notice that I was going to be moving the amendment. I have had an opportunity to have the amendment looked at by legislative counsel for legislative appropriateness; at least, drafting appropriateness, not policy appropriateness. That is for you to decide, of course. So I had better move that.

The Chairman: Mr Reville moves that section 7 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following subsection:

"(7) This section applies, with necessary modifications, to a person as though the person operated an independent health facility on the 2nd of June, 1988, if the person, before the coming into force of this section, was operating a health facility and charging fees that were set out in a column denoted by the letter 'T' in regulation 452 of the Revised Regulations of Ontario, 1980 made under the Health Insurance Act if, before this section comes into force, those regulations are amended so that those fees are no longer set out in such a column."

Mr Reville: Is that not amazing?

The Chairman: I am impressed.

Mr Reville: I can speak briefly to it. The speech that I have made a couple of times already still remains. But the amendment may sound a bit odd to you. The amendment basically will deal with the 304-odd private diagnostic radiology operations that we know of and that are currently licensed to do that function.

1440

Basically, if the regulation to the Health Insurance Act is amended, it will treat the technical fee, the T fee, as a facility fee. It will grandfather all those currently doing diagnostic radiology, and if they so desire, within a year they could apply to the Ministry of Health for a licence to operate an independent health facility, and the ministry could look at its numbers and make a determination on whether it wanted to fund such a facility.

The way diagnostic radiology is treated, it is one of the anomalous operations in the health care system whereby a fee over and above the insured service fee is allowed for and is paid for. I have been concerned about what I think is fair to describe as almost exponential growth in this area. By Order and Notices question on 12 June I asked the Ministry of Health to provide, for a recent complete year, doctors' billings to OHIP arrayed in descending magnitude in a one line per amount billed format, and this is what I got. This is a printout, my friends. It goes on for many, many pages.

The interesting part is that the ministry helpfully provided additional information that showed which of these billings were in relation to diagnostic radiology. The top billing was \$4.1 million, \$3.75 million is the second, \$3.08 is the third and on down. The information provided by Dr MacMillan indicates that the 12 largest diagnostic radiology clinics bill in excess of \$1 million per year each, account for 20 per cent of the \$80-million expenditure in this connection and have increased over last year by almost 25 per cent.

This seems to indicate to me that a mechanism to try to assure quality

and appropriate utilization would be useful. If anybody ever wants to look at this, it will really---

Mr R. F. Johnston: Knock your socks off.

Mr Reville: "Knock your socks off," was the offering from my colleague. Basically, the top 12 billing numbers are over \$2 million a year per OHIP number. Those are big operations and a big cost to the taxpayer. To the extent that we can try to make sure that health expenditure more approximates health status, I think we should do that.

Members of the committee may want to inquire of staff whether they believe the problem is accurately described and that the amendment will do as I have suggested it will do. I think it deals with the fairness question, that the 304 people will continue to operate as before, but if they choose to become an independent health facility they will have to apply.

What it does is change the number of grandfathering types from the 20 we described a few minutes ago to around 325. So this is a matter of an \$80-plus-million-a-year health expenditure. It is a significant amendment. I do not want to mislead anybody in that connection. It is a significant change in policy and would be a significant difference, if these facilities were to become independent health facilities, in the way the money is flowed from government. I do not want anybody to think this is chicken feed stuff. This is big stuff. I think it is important and I think it is right. I will just leave it there to see what people want to discuss.

Should anybody desire this information, by the way, I would be happy to make it available. It is here. Come and take a look at it. Take it home. Read it at night, whatever.

The Chairman: As you mentioned the figure, I am just asking for a point of clarification. Will this amendment add to the cost of the ministry?

Mr Reville: I cannot answer that question. I would assume the ministry already has some procedures in place whereby it monitors the flow-through of this. Whether it is a neutral cost or not, I cannot say.

The Chairman: There is a question of a point of order in terms of an opposition member moving this amendment.

Mr Reville: It does not require the government to make an expenditure.

Mr R. F. Johnston: That is right. That is what would be out of order.

The Chairman: I just wanted to get that clarified.

Mr Carrothers: I would make that same comment, that it seems it is only tangential. Any amendment costs an administrative cost, which I suspect is what he is raising, but it is not---

The Chairman: I just thought I would get that clarified.

Mr Eves: I am in support of the principle that Mr Reville has enunciated. As I understand it, having discussed the matter with the minister and others, something like this was requested by the Ontario Hospital Association and the College of Physicians and Surgeons of Ontario.



I might ask the minister what the ministry's position is with respect to the amendment, but I think I already know the answer to that. But I want to know what happens if we catch a group or groups of persons, if you want to put it that way, that we are not intending to catch.

Hon Mrs Caplan: The motion responds to an issue that was raised by the college of physicians and surgeons on the issue of diagnostic facilities and its concern regarding quality assurance in those facilities and the proliferation of those facilities. It was also raised by the Ontario Hospital Association. I made the point when the college was here of committing to work with them to look for mechanisms to respond to that concern, which I think is a justified concern.

The amendment that has been put before us is an approach that would allow us to ensure that in the future all diagnostic facilities would be properly planned, that we could have advice from the district health councils as to where they should be located. The Ontario Hospital Association's concern would be addressed by this amendment.

But there is a concern the member raises: What about those who are captured by this? I think it important to put on the record that the regulatory ability to exempt is one which will allow us to determine where it is appropriate to be covered by this act and where we can, by regulation, exempt those not intended or not appropriately covered by this act.

It will also allow us, and I make the commitment, to consult with the college of physicians and surgeons, the Ontario Hospital Association and the Ontario Medical Association to ensure that the implementation of this made sure that those who are presently being grandfathered were fairly responded to, and that there was the intention to appropriately plan in the future and develop the kind of mechanism that would make sure that concerns which have been raised about diagnostic testing facilities were properly responded to in the public interest.

This amendment does address some of the concerns that were raised here at committee. They are legitimate concerns about the diagnostic testing facilities, and we have no objection from a policy point of view to incorporating it in the act at this time.

The Chairman: Shall the amendment carry?

Motion agreed to.

The Chairman: Is there is any further discussion on section 7, as amended?

1450

Mr R. F. Johnston: I would like to deal with the notion of whether the minister feels she has sufficient control in terms of deciding that a service is not appropriate under the act, that a clinic established for one purpose or another, under the act, grandfathered or otherwise, is not functioning in the way you wish it to. Do you feel that the sections you have at the moment in the act are strong enough to make a determination that would exclude the clinic from operating a year or two down the road?

Hon Mrs Caplan: The intent of this section is that the director, where there is cause—and I think cause is extremely important—for concern,

as there is now in a public hospital where in the public interest the minister and the ministry have cause for concern, they can in fact, under the powers of the Public Hospitals Act, move to ensure patient care, appropriate governance and all of those issues, which are in the public interest.

In this case, where there is cause, the director can act and can act appropriately to ensure quality of patient care and the public interest.

The question of renewal of licence is the one you are referring to now. There were a number of reasons for the five-year licence: We talked about financing and the term of the licence being one which was appropriate to service delivery. The purpose of the discretion at the end of the licence allows for the opportunity to reassess changing technology. We know we are in rapidly changing times; often by the time equipment gets in, it is obsolete in the second and third generation. This would allow us to ensure that at the end of five years we were able to assess the need for that service, any advances that were made, and if we decided to renew the licence, it would be with the obligation of ensuring the latest quality of care and new technology. It would also permit in the assessment of need whether there had been new developments in treatment procedures and that sort of thing.

What this bill really says is that licence renewal is not automatic, that need is to be determined, and it would take account of any changes that had occurred. It would allow for need assessment to be made upon the reissuance of the licence. If we learn anything from the past, I think it is that often the issuance of a licence was something that then determined in perpetuity and the licence became a commodity unto itself.

The intention of this is that the licence not hold any value and that it be related to the needs of the community. We believe that this act responds appropriately to that but builds in all of the important due process provisions. That is the reason this is landmark legislation, in that a decision of the minister taken not to renew is appealable to the executive council and to the cabinet. That is very significant. This is the first piece of health legislation that has that kind of appeal to cabinet of a ministerial decision.

Mr R. F. Johnston: I agree with your analysis of it. On that basis, my concern and my question are basically on the Colodny clinic. We have a proposed solution, I hear between the lines, for the birth centre; it sounds like it very well might get a proposal call and be easy to get on stream. There has been no acceptance of either of Mr Reville's amendments around the dates which would make it easy for the Colodny clinic to come in.

One of the arguments against that is that although we do not know of any other clinics that might be concerned that they would or would not be brought in under this act, one would presume they would have come forward by now because of their own economic self-interest in this whole thing. Even though we do not know of any others, the fear that there might be others out there has made us not change the date, yet I am hearing that, due process obviously being protected, the minister has pretty substantial powers in terms of limiting the length of time one of those grandfathered operations would continue if it was being operated prejudicial to health or whatever, that you have a fair amount of power in that area.

I am looking for a practical means of making sure the Colodny clinic can continue, obviously. I would hate to see only two clinics operating rather than three after this bill comes forward.

Therefore, I am wondering where the flexibility from the government's perspective is going to be shown in terms of that clinic, which has been operating and providing services. Is it possible that, at a date closer to actual proclamation, you might accept an amendment to the dates that would allow it to operate? In other words, if we were to go into committee of the whole just before third reading and third reading only took a day—obviously, nobody can start up a clinic overnight to fit this bill—would that be a more appropriate time in your terms for an amendment? What is the solution? Or is the Colodny clinic going to be let go, be the one victim in this process?

Hon Mrs Caplan: It is my view that the act was very clear when it was tabled on 2 June 1988. The determination at that time was that any future women's health centres would be responded to fairly in the community by anyone who wanted to provide those services following a request for proposal. It seems to me that that is the appropriate and fair approach and that the selection of any other date would simply be arbitrary and unfair. As I said, the intent of the ministry is to look at the orderly development and expansion of appropriate services after needs have been assessed, and following a request for proposal, licences would be granted on the basis of the merit of the proposal that came forward.

Mr R. F. Johnston: That is no less arbitrary than deciding that three birthing centres should have proposal calls, and not having specific numbers and locations for these other clinics which might give some hope to women who have been relying on these services. I am getting a blacker and blacker view of this initiative.

The Chairman: Any other discussion on section 7, as amended?

Okay. It might be an appropriate time for me to ask the committee whether we should carry on with the same approach. Do we know all the amendments are going to be—

Mr Reville: I think you might as well just carry on. We are doing fine.

Section 8:

Mr Eves: I have two amendments with respect to section 8 which we discussed yesterday, so I am not going to belabour the point. In my amendments for subsections 8(1) and 8(2), I am asking that we go back to the bill as it was originally printed, where written reasons have to be given in every instance. The only rebuttal we received from Mr Sharpe and the ministry with respect to the section as originally written was that it would be somewhat onerous in an administrative sense for the ministry to have to provide written reasons in each instance.

I think we have to try to balance that with the fact that people are entitled to know why their requests have been denied. I do not think it should be necessary to require them to apply to find out why their proposal was rejected. I also am concerned somewhat about the section the way it is worded now, because you can request written reasons, but the ministry may take a year or two years to respond. There is nothing in the act that has a deadline by which they have to respond. After they have received the written reasons they can request an appeal, but that may be many months down the road after their proposal has been rejected. Those are my reasons for moving the following two amendments. Do you want me to deal with them both or one at a time?



The Chairman: I would take them one at a time. They are to do with two different subsections.

1500

Mr Eves moves that subsection 8(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"8(1) Where the director proposes to issue a licence under subsection 6(1) or to refuse to issue a licence to any person, the director shall give notice of the proposed action, together with written reasons therefor, on every person who submitted a proposal for a licence."

Mr Reville: I support Mr Eves's amendment. It makes eminent sense to me to provide people with reasons.

Mr Carrothers: I do not disagree with what Mr Eves is saying, certainly in terms of people having a right to know why their request is being denied, but I think when we are writing a statute that is to apply in every single case, in all circumstances, at any time, it becomes a bit onerous to put something like this in the bill, so I do not feel I can support this amendment.

Mr R. F. Johnston: It is onerous to inform people what the reasons are? Democracy is onerous. There is no doubt about it. It is a little messy and mucky sometimes, but it should be. If it is bureaucratically a little awkward, so what? Do people not have rights? What is this notion? Liberals coming forward that it is a little too onerous to let people know the reasons. Was this not part of the bill in the first place? When somebody started dreaming up this notion of a legislative approach, they saw fit to understand that people were to be given reasons at that point. Now, for bureaucratic convenience or whatever reason, it is too onerous. This is a really interesting devolution.

Mr Reville: I have an additional comment to make. It is estimated that in the year 1990-91, which would probably be the first full year of operation of an independent health facility, this onerous obligation would amount to five sets of written reasons, according to the ministry's estimation. I do not think that is onerous, even if it were 50 times 50, to paraphrase a book that has more authority than most of my books do, those written as well as unwritten. That is the end of that speech. Good, though, was it not?

The Chairman: Yes.

Mrs O'Neill: As we have agreed with this amended version, the amendment does say that there are going to be requests made and requests attended to and written reasons given upon request. That is the way every single other statute in this province is written, and that is why we changed this to accommodate—

Mr R. F. Johnston: Not so.

Mr Reville: Pshaw.

Mrs O'Neill: It is in the statutes. That is the tradition in this province and it is certainly what I remember from some of the statutes in Education.



Mr Reville: It is pretty hard to expect the Ministry of Education to be able to write while other ministries cannot.

Mrs Cunningham: As we get started in approvals, normally the reasons for getting licensed, the objectives, are all written out anyway. I think the most interesting part, and probably the most difficult challenge for the government, is going to be telling people why they are not getting licences, especially people who have been operating and may be refused. I think they deserve, especially if they have been operating, to have the answers in writing and in most instances we do it.

I think this amendment only goes to show the public that we are not afraid of making a decision and giving the response in writing and that we stand up for what this bill is all about. I cannot imagine anybody using the word "onerous." There may be other reasons, and I would like to hear them, but that one does not sell me at all and certainly should not sell any member of the public either.

Mr R. F. Johnston: Reading clause 8(2)(a), it says, "written reasons for the proposal if a request is received by the director within seven days."

Mrs O'Neill: Why can it not be done before that?

Mr R. F. Johnston: Seven days?

Mrs O'Neill: Certainly it takes a while to prepare these things properly.

Mr Carrothers: I think Mr Johnston has already drawn the attention of the committee to the section I wanted to indicate to Mrs Cunningham. There is a procedure to get written reasons. The point I was making is that there are going to be many requests made, some of them perhaps very minor, and to require a written response for every single one of those creates a requirement that is indeed onerous.

That is not to say, as I said at the beginning of my comments, that it is not right that in many cases they should be given reasons. This allows those who are not given reasons—I would suspect that as is the practice in most cases where a substantive request is made, there would be reasons given in the normal course in any event, but there is a procedure in this bill to request reasons.

It is for those minor small ones. I go back to the point that when you are writing a statute that applies in every circumstance, in every case, at all times, you have to be very careful you are not creating a requirement that is onerous. This amendment would do just that. It is not taking away the ability of people to get reasons in those cases where it is justified. On a substantive thing, I would think that in most cases that would happen.

Mr R. F. Johnston: Community boards have managed that in seven days?

Hon Mrs Caplan: The existing practice and the requirement under other pieces of health legislation is that where a request for reasons is made, it is responded to and there are debriefings, that sort of thing. To have a requirement in the act would in fact build exactly the kind of bureaucracy to respond where people may not want a response.

Mr Reville: Come on.

Hon Mrs Caplan: In looking at it, wanting to make it consistent with the practice that is in place right now, we felt that this was a more appropriate approach and that anyone who asks questions, whether they are questions in Orders and Notices, responses to letters, requests under freedom of information, all of that is available, but to make it a statutory requirement that you have to reply whether or not the request was made, all that would do is add to the number of people in the department that is going to have to administer this act. It is not a major issue.

Mrs Cunningham: I do not want to belabour the point, but when you take a look at what we are requiring the public to do to get a proposal, for those of you who have travelled about to take a look at proposals, especially for health facilities, for different health programs, for education programs, people are having to hire extra staff at their end now to put the proposals together. We have four or five different approval stages of proposals to get money from the government because we want to make certain we are getting the best information.

For people to go through that process and not to get a letter stating why they were turned down after literally hours and sometimes years of work to put proposals together---I am not exaggerating; some of these things take a long period of time---a letter stating the reasons why, almost makes us look somewhat defensive about saying no. Even if the reason is that there is no money left, I think that to put it in writing is just a courtesy, considering what they did in order to even apply for the licence. The requests are rather significant and so they should be. To me, it is just a matter of courtesy.

Hon Mrs Caplan: Just to restate it again from the ministry's perspective, anyone who requests a letter or reasons is automatically attended to. We do not see this as a major issue. It is a question of whether or not you feel strongly, committee, about wanting to add additional ministry staff to respond when there may not be even a requirement or a desire to have that response. I would leave that in the hands of the committee.

The Chairman: Is there any further discussion on this amendment? Mr Eves, do you wish to close off?

Mr Eves: I do not want to belabour the point any more, other than to say that the amendment I am moving is exactly the way the Ministry of Health drafted the bill in the first instance, so they are arguing against their own original bill.

Hon Mrs Caplan: That is correct.

Mr Eves: I quite agree with Mr Johnston that to expect somebody to respond within seven days is a little bit onerous in itself, I would say.

The Chairman: We have heard all the discussion. Are we ready for the question?

All those in favour of Mr Eves's amendment will please say "aye."

All those opposed will please say "nay."

Motion negatived.

The Chairman: Mr Eves, you have another amendment.

1510

Mr Eves moves that subsection 8(2) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"(2) A notice under subsection (1) shall inform the person on whom it is served that the person is entitled to a hearing by the board if the person mails or delivers, within 15 days after the notice under subsection (1) is served on the person, notice in writing requiring a hearing to the director and the board, and the person may so require such a hearing."

Mr Eves: There is no point in reiterating the same arguments. They have all been made. We are just trying to reinstate what was in the bill in the first place.

The Chairman: Discussion? Shall Mr Eves's amendment carry?

All those in favour will please say "aye."

All those opposed will please say "nay."

Motion negatived.

Section 9:

Mr Eves: I have several amendments with respect to section 9, but having talked to Mr Sharpe and also having talked to legislative counsel, I believe this matter can be clarified by a slight clarification in language. I just wanted to make sure, and I asked the question yesterday and the ministry assured me that we are both of the same opinion, that this section deals only in a case where the minister has made a request for proposals and the ministry has decided, for whatever reason, that it is not going to go ahead with that request for proposals, is not going to accept any one person's proposal.

I would like to try to clarify, at least I hope I am clarifying, the language in subsection 9(1) and the language in subsection 9(3) so that they are both identical.

The Chairman: Mr Eves moves that subsection 9(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out "a licence to any person" in the fourth line and substituting "any licence in respect of the request for proposals."

Motion agreed to.

Mr Eves: Similarly, with respect to subsection 9(3), I would like to make a similar amendment so the language is consistent throughout the section.

The Chairman: Mr Eves moves that subsection 9(3) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out "a licence to any person" in the second line and substituting "any licence in respect of the request for proposals."

Motion agreed to.

Mr Eves: I wish to withdraw all the other amendments I have tabled to section 9.

The Chairman: That is good because I was going to suggest that a couple of them were out of order. Any further discussion on section 9, as amended?

Moving along to section 9a. There is a 9a at the bottom of page 9. Any discussion on that?

Section 10:

Mr Reville: Mr Eves and I will disagree in this connection.

Mr Eves: I am sure I will be a very lonesome figure on this issue but I might get some support from the ministry.

Section 10, as the bill is drafted right now and it is fairly clear, simply states that a licence is not transferable. I think this problem should be addressed. We heard several delegations and individuals who came before the committee indicate that a licence indeed should be transferable and there may well be plenty of instances in the operation of the bill, as time goes by, where you would want a licensed independent health facility to continue on.

I do not think it is—at least I hope it is not—the ultimate intention of the government that such a licence could not be transferable to allow that facility to continue.

1510

I suspect that where I may run into some disagreement from the ministry is that I do not see any difficulty, when a licence is transferred, in allowing there to be goodwill attached to that venture or to that independent health facility.

I would not suggest that there should be money paid for the licence, per se, but I realize that could be a somewhat grey area when you get into talking about anything if you are going to attach a value to goodwill or what it really means. I suspect the government may not agree with me on that. However, be that as it may, I am going to move that section 10 be changed as follows.

The Chairman: Mr Eves moves that section 10 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"10(1) A licence is not transferable without the consent of the director.

"(2) In deciding whether to consent to the transfer of a licence, the director shall treat the proposed transferee of the licence as if the proposed transferee were an applicant for a licence and for the purpose of subsection 6(1), other than clause 6(1)(a), applies with necessary modifications."

Mr Eves: As committee members will see, you are not unilaterally or arbitrarily entitled to transfer your licence. The director is going to have to treat this proposal as if the proposed transferee was an applicant for a licence. I think that contains the necessary safeguards to prevent licences to be transferred.

Mr Carrothers: I am pleased Mr Eves has mentioned that he agrees licences should not have a value attached to them. What he is proposing here is some flexibility with transfer, which is interesting. I know we had



discussed previously some of the possibilities that might arise surrounding partnerships and estate problems that come into play. I think there was some discussion from the ministry that it could be taken care of in other ways, but this type of amendment could indeed allow the flexibility to deal with some of those unusual situations surrounding a licence.

However, I do not think that standing by itself, Mr Eves's proposal deals sufficiently with the question of under the table or other kinds of payments. Mr Eves has already mentioned goodwill. I think there are doctoral papers in accounting on what goodwill is. It can be just about anything you want it to be.

I am going to move some amendments to Mr Eves's amendment if I may, which I believe have been circulated.

Mr Reville: Just this minute. It is a miracle.

Mr Carrothers: It is a miracle, is it not? Word processing has been very helpful today, I think, Mr Reville.

Mr Reville: This is more like inspiration.

The Chairman: Mr Carrothers moves that the motion moved by Mr Eves be amended by striking out subsection (2) of the proposed section 10 of the bill and substituting the following therefor:

"(2) In deciding whether to consent to the transfer of a licence,

"(a) the director shall treat the proposed transferee of the licence as if the proposed transferee were an applicant for a licence and for the purpose of subsection 6(1), other than clause 6(1)(a), applies with necessary modifications; and

"(b) the director shall apply the principle that consent shall be refused if there are reasonable grounds to believe that money or other consideration other than the prescribed fee, has been or will be paid, transferred, accepted or received for the transfer of the licence.

"(3) No person shall pay, transfer, accept or receive money or other consideration other than the prescribed fee for the transfer of a licence.

"(4) Every director of a corporation that transfers a licence shall take all reasonable care to ensure that no money or other consideration other than the prescribed fee is paid, transferred, accepted or received for the transfer of the licence."

Mr Carrothers: I think there would need to be some supplementary amendments made to other sections when we get to them.

Mr Eves: I want to ask of the ministry whether it is the intention or the result, through Mr Carrothers's amendment—say there existed an independent health facility that had a licence and that facility was being transferred to some other entity or other person, would this amendment that is being moved by Mr Carrothers preclude somebody paying goodwill as opposed to a stipulated sum for a licence?

For example, and maybe this is not a very appropriate parallel, but if

you are buying a trucking business, lots of licences attached to various types of trucking businesses, usually when you enter into a commercial agreement of purchase and sale, in such an instance there is a stipulated value for those licences, and there may be a totally different value for goodwill.

If a similar situation were to happen in the future in an independent health facility, is it the intention of the government that the amendment moved by Mr Carrothers would preclude just the payment of a stipulated sum for the licence, or would it preclude any payment whatsoever for goodwill?

1520

Hon Mrs Caplan: The amendment to the amendment, deals with an issue that I feel very strongly about from a public policy point of view. The issue that you raised is one of what if someone dies or, if it is in the public interest to allow a licence to be transferred, which would allow for the sale of a building, the transfer of equipment and so forth, if it was determined that in fact the service should continue, and because of some unforeseen circumstance.

I think that is a point well taken, but I feel very strongly that there should be no value attached to a licence or in fact to goodwill which would allow for a market to develop around the licensed nature of the facility. I feel that it is in the public interest, in the kind of circumstance raised here with some of the people who came forward and said that there could be a circumstance where, in the middle of a term of a licence, it became necessary to transfer for reasons which, with the consent of the director and the ministry, seemed appropriate, it still seems to me that the amendment to the amendment determines that there would be no value placed on the licence or on the term "goodwill" which is the value of the licence for the procedure. I think that is an important public policy question.

The health facility fee is to respond to the operating cost of the facility, that is the intent of that fee, as well as the fee for service component. The notion that there is any additional value attributable to the licence itself, I think is not in the public interest.

Mr Eves: I agree that a particular value being attached to the licence itself is not what we want, but I also—

Hon Mrs Caplan: That is what goodwill is.

Mr Eves: No, it is not what goodwill is. I just gave you the example of the trucking company. I have closed several transactions like that myself and there is very often a very substantial sum attributed to licences when they are transferred, and another very substantial sum attached to goodwill. What I am asking you is, are you just trying to preclude payment of the fee for a licence or are you trying to preclude somebody from selling the goodwill that they have built up in their independent health facility that they have operated for a number of years.

I can support the concept of not being able to pay for the licence, but I cannot support the concept of telling somebody that they have operated a facility for a great number of years perhaps, that the Ministry of Health decides that they provided such a good facility and provide such a valuable service to the public that they want that facility to continue, and then you are going to tell that individual or individuals that they are not entitled to reap the benefits of the facility that they have built up over a great number

of years, because that is what you are saying, if in fact you are precluding them from selling the goodwill of their enterprise.

What you are going to do is probably encourage people to attribute more value, heaven forbid, to lands and buildings and equipment than perhaps they should, so they can get their goodwill out of this one way or another. That is the reality that is going to happen in the real life application of transfer, I would suggest, if you force people to do that.

Mr Reville: I do not believe that this amendment to the amendment prevents the sale of goodwill at all. I think what it does is prevent consideration for a licence. I think we are lucky that we have a corporate expert here. Do you not think this relates only to the licence, Mr Spence? Am I putting you on the spot?

Mr Spence: It is stated to refer to the licence. Listening to the discussion that has ensued, I have wondered how you would distinguish between consideration for the transfer of the licence and goodwill. In principle I would think the only way you could make the distinction would be if you could show that the goodwill was referable to the activities carried on without reference to the licence, and I would have thought that a tall order.

Mr Reville: People who do corporate beautifications would surely figure out a way to get some money for goodwill out of this. It is my view—

Mr R. F. Johnston: Corporate beautifications?

Mr Reville: Actually, that is a real term.

Mr R. F. Johnston: I like it. I like it a lot.

Mr Reville: That is how you make a company that is not worth very much worth a lot more. Ernie Eves' trucking image takes me back 25 years ago when I was working for a commercial law firm, which did a lot of trucking legislation, and my job was to sit and write a new trucking bill. It just about drove—in fact I think it did drive me nuts, now that I think of it. I am worried that the minister is going down the wrong road here.

Mr R. F. Johnston: With no brakes.

Interjection

Mr Reville: That is right.

Mr R. F. Johnston: The air brakes not functioning.

Mr Reville: That is right. This is not 38, it is old 97. Actually, that is a train image.

Mr R. F. Johnston: Mixing our metaphors again. It is hard.

Mr Reville: But, of course, the trucking industry has learned how to deal with that.

Mr Eves: What train is it?

Mr Reville: With its piggyback. We actually were writing piggyback laws in 1964, remember that. The government amendment seeks to prevent the



exchange of consideration for these licences. I know it is wrong to try to be eclectic and to try to transfer learnings from one field to another, but my friends, if you want to try to prevent the exchange of consideration to rent an apartment, you are whistling Dixie.

Key fees are being paid even as we sit here hoping that maybe we can prevent the exchange of consideration for these licences. I think this will create independent health facility licence futures. Get your money in now, see if you can sell short on a few. I think that it is really dumb. I think that the ministry has changed its mind at the wrong time here. I think these licences will indeed be sold and you try to catch them. You will not be able to because they are clever people out there.

The penalties which I see in succeeding amendments are confiscatory, they would just take the whole amount of the consideration if you could in fact determine what it was. The consideration will be a peppercorn. They will give you your peppercorn back and laugh all the way to Miami. I am going to oppose this whole package.

Mr R. F. Johnston: Oh, we are against it?

Mr Reville: We are against it.

Mr R. F. Johnston: Since we are against it, I think that this is very wrong-headed as well; you may be surprised at that. Independent of my colleague, I came to this consideration. I think what has happened here is one of those dangerous things that does happen sometimes in drafting legislation in a committee, and it has been referred to before by my colleague. There is a nervousness about the absolute nature of the prohibition, for whatever reasons, and one can think of a number of scenarios where transferability would be better than seeing a community clinic go down the tubes, for one reason or another. Therefore, there is a scurrying at the moment to try to deal with that.

I caution that some time should be taken, some reflection about this kind of matter, not just because of the matters which have been raised by Mr Reville, with which I concur, but to do with other kinds of things. I do not see any notation in here about the question of transferability of a nonprofit to a profit situation, and I am not sure that we should not have something very specific in the bill about that whole question. Do we really want to see a nonprofit community-based group that is in danger of disappearing for one reason or another, all of a sudden transfer itself to a profit-making group or ambit. There is nothing in here about corporate concentration.

1530

I just remind members of the situation in the nursing home field at the moment where whole communities, large communities, like Ottawa and other areas are almost absolutely controlled by a couple of companies that provide all the nursing home care in those areas.

There is nothing in this that lays down guidelines of any sort about whether we think that would be a good thing if all of a sudden an American multinational corporation, for example, started to assume the licences for a number of organizations at face value, seemingly not making any major profit on the exchange of the licence or whatever, but developing a monopoly.

I understand the need to look at this matter and I am not saying out of



hand that we should not touch section 10—and I know my colleague and I have not discussed this in any detail—but I am very nervous that it might be presumed that Mr Eves's amendment and this one together are going to solve problems and not create a number of problems. So I would just caution that we not move down this route too quickly today. Maybe this needs some more consideration. I have been joking about reopening things at COW, committee of the whole, but it may very well be that this is the kind of matter that needs, on reflection, to be reopened again later on at committee of the whole House, if you want to go this route.

Mr McClelland: Two or three brief comments. With regard to the analogy that Mr Eves makes, I understand where he is coming from and I would just like to say very clearly that I do not see it as an appropriate analogy to discuss a business enterprise wherein people undertake business for profit specifically, without getting into all the whys and wherefors, to draw a consistent or parallel analogy with provision of health care. The minister stated very clearly in terms of the provision of services to the public. I think it would be kind to say that we are comparing apples and oranges even in that case. So I do not find that the argument flows necessarily from the analogy that Mr Eves uses, although I understand he is using it to illustrate a potential problem.

I would like to take a look very briefly and talk about a possible scenario as it is written in our deemed document here, section 10, "A licence is not transferable." Let's talk about the practical reality of what is going to happen in that situation. Mr Johnston alluded to it and to the community services being provided, and the providers or operators of that service decide, for a variety of reasons, to terminate that service. Something is going to happen; there are certain things that are going to take place. The actual versus the apparent scenario may be somewhat different.

I would suggest, although it is impossible to speculate in total, but in all probability it is going to be very widely and quickly known among the medical profession and people that the provider of service in community A is about to cease that service. In effect, what is going to happen is that an application is going to be made for another licence. The reality of that—and I think we are just using semantics at this point—is that we effectively have a transfer. They are going to come in, and I think Mr Johnston and I might agree that somehow—you can package it however you want—somebody is going to come in, and by means of reapplying, is effectively having a transfer of that same service and providing it.

Having said that, what we have here is a situation, with the amendment to the amendment proposed by Mr Carrothers, recognizing that you will never close every loophole—I agree that people will find ways. I do not like to ascribe negative motives to people, "devious" if you want to use that word, but certainly people will be creative in finding ways to benefit financially. Having said that though, what the amendment to the amendment seeks to do—and I think it is a reasonable position—is to control, monitor and provide some authority to the director to control the transfer of licences.

I would suggest that saying that a licence is not transferable is, in effect, naïve, quite candidly, because the end result in almost any scenario is going to be a transfer in kind. It is going to have the net result to the community that the same services will be provided by somebody else. The grapevine will work. People will be in there with an application.

I think the amendment to the amendment provides a mechanism whereby

there is monitoring; things are aboveboard; there is communication. The director, in clause 10(2)(b) looks at all the facts, the reasonableness of the consideration, and can then make a determination. I do not think we are ever going to find perfection, because people are quick to realize we do not live in a perfect world, but I think it is a reasonable and good method of controlling the transfer, making sure that it is done in a responsible way, with the provision of that care as the primary concern for that community.

Unless—and I say this with great respect—we come up with something that I can be convinced provides a much better alternative to the amendment as amended, to provide that control, to provide that monitor for the effective and wise transfer of licences, I will be supporting the amendment to the amendment and I would invite comments from my friends on some creative alternative. I say again that I think what we have to look at is the potential scenarios that would occur in any community and the need to provide some effective control and monitoring of transfer of licences. So I will be supporting the amendment to the amendment, as I said, waiting to hear what other wisdom may issue forth in the next few moments.

Mr Owen: I suppose I want to end up with a question to the minister, actually, but leading up to that, we know that the essential thrust of this bill was to provide quality health care, but in ways in which it would be less costly in terms of dollars than some of the ways in which it is being provided now.

When I looked at section 10 originally, it said "A licence is not transferable," period. All of us have many examples in our background where we have seen that the people involved in that particular area of service, who were saying they needed more help and they should be reimbursed more, they still ended up with licences which seemed to be very valuable when they were involved in the transaction. We wanted to avoid that here. If the wording was left the way it was, then it probably would be successfully avoided.

Then in hearings, we have heard from people who have come here and they cause concern to us because they say: "We have a business and my son is wanting to continue the business. He has been working with me and whatnot." We do not want to deprive the community of this type of service, this type of experience and expertise. We do not want to disrupt the son carrying on. I suppose if there were shares involved in the operation, the shares could be carried on with the father and the son, but we still do not want to hurt them. So I suppose we are looking at some way to help them, and in the process of helping them, I hear Mr Johnston saying, "We are really opening up the back door to cause the problems."

My experience around here has also been that often, if we leave it simple and straightforward, we have it. And often when we try to start to open up words and accommodate problems, it actually created more problems.

So my question which I am leading up to with the minister is that if we had left it the way it was, that it was not transferable, and if the father-son clinic was coming to us saying, "We would like to apply because we know we are going to be looking for a service," would not the ministry be taking into consideration the fact that there is a proven track record on the basis of the one that is already there? Would it not take into consideration that the equipment and the facilities are there? Would it not take into consideration that the people in that area have been having that particular need looked after? Would that not be a consideration? I know we have to look at other proposals, but in looking at all the proposals, would you not

consider the one where we were trying to avoid this problem that we were given a few weeks ago? I guess I am asking how we balance it. If we had left it the way it was, was there not a structure in place whereby we could have met that problem and avoided future problems?

1540

Hon Mrs Caplan: The answer is no. As the bill was structured, we could not have responded to the issues that were raised, the one you identified. The amendment to the amendment proposed by Mr Eves is very clear and specific.

Further, in section 31 of the government motion which has been tabled, I think what is very important, as it also responds to the concern raised by Mr Johnston—because of our desire to make sure the licence itself has no value and because of our desire to respond, and I think that is the motive of Mr Eves, as well as our understanding of the unusual circumstances: what happens in the case of a death, what happens in the case of a group saying: "We just don't want to do this any more. We'd like to transfer our licence to somebody else."

The bill as it is printed had no flexibility to be able to respond. We have added penalties. It is an offence with very severe fines and penalties if there is consideration in dollar value attached to the transfer of that licence. So there are safeguards: the safeguard that the director must approve the transfer, so it would have to respond to the kinds of circumstances that have been identified here; second, if there is a determination that there has been a fee paid or that the licence in fact did attach a value to it, then there is not only the penalty but also the actual amount that was paid becomes part of the fine. I think that says very clearly that the intent is that the licence itself not have a value, that the intent of the original bill stands but that it gives us, and I think properly, the ability to respond to those kinds of circumstances which had been raised.

Where I differ and where the policy decision differs from the motion that was placed by Mr Eves was that he said quite clearly he feels that there should be able to be a value for certain aspects of goodwill and so forth; we do not agree. That is why we placed our amendment, which would ensure that if there was a circumstance where a licence was transferred, it would not have a value attached to it.

Mr Owen: Supplementary to that, are you not still leaving the door open for the example Mr Eves gave of where they will simply say: "As part and parcel of taking over this business, you're going to have to buy the building." Maybe it was worth \$200,000, and now it is going to be worth \$250,000 or \$275,000. Are you not still leaving it open that the licence will have no value but they are getting it other ways?

Hon Mrs Caplan: The land and the equipment will have a value. The director would have to approve the sale and because the ministry annually negotiates—

Mr Owen: Are you going to be checking those values of other things?

Hon Mrs Caplan: Outside of the actual annual operation and function of the business, it would depend upon what the relationship was to the space and to the equipment within the component of the facility fee. That would vary from licence to licence as to the terms of the licence. I will ask Gil to just clarify that.



Mr Sharpe: I would think that the director, before giving approval, would want to look at all details of the transaction to determine the bona fides and to ensure, for example, that fair market value and no more is being paid for the assets. Again, in keeping with the provision here and in the package that was distributed, there is a very stiff penalty provision that is going to be moved later on. The notion is that there is an obligation all around to ensure that there is no extra consideration being paid for the assets that might be attributed to value for the licence.

Mr Owen: How would you check it? How would you know that the building was only worth \$200,000 in Barrie when it probably sold for \$350,000 in Toronto and they are going to charge maybe \$300,000?

Mr Sharpe: Again, I cannot prejudge what criteria the director would impose, but I would assume that in order to do a thorough job—and one would not anticipate that these matters of transfer would arise very often—it would be incumbent on the director to ask for local appraisers to provide input and information as to what the present fair market value would be of those assets in that community.

Mr Owen: I hope Mr Johnston heard what you just said. It would be incumbent upon the person processing to ask for appraisals to verify that there would be no inflated values.

Mr R. F. Johnston: I do not know whether you want me to respond at the moment. It does seem to me that this is going to require another whole set of regulations that you had not thought about up to this point. This is one of those attempts at a quick fix to a problem, which I think sometimes does create some further problems.

I am not a business expert, goodness knows, with all my prejudices, but I do not understand how this all fits in when you are going to have a public corporation with shares and values being augmented because of the acquisition of a range of these corporations, and then what effect the licence really has on all of that anyhow. I do not understand exactly what will happen if you do have a corporate entity buy out a nonprofit, who gets the bucks if that nonprofit is in the process of falling apart and all those kinds of things.

It does strike me as an awful lot easier to deal with if everybody has to apply. Some organization is going down for one reason or another, it becomes known, and then requests for a new licence are made by groups in the community. That seems to be an easier way of evading some of these difficulties.

I am not saying that you cannot solve the problems that are here. I guess I am just saying that, just thrown at me as it is now, at the moment I can envisage difficulties. Maybe I am too much of a naysayer after all these years in opposition, but I worry about us coming up with a quick fix to something which was obviously thought through before the bill was brought in. The more absolute terms of section 10 as they are in the bill may have been more appropriate.

I do not know where the burden-of-proof questions lie in these kinds of matters where we are saying "on reasonable grounds." I know what that means in other kinds of laws we have passed, but I am not sure what reasonable grounds would actually be in the case of a director and how nice an acquisition of information he or she would have had to get before making the determination. It just makes me uneasy when I see this major switch so fast.



Mr Carrothers: I understand Mr Johnston's concerns and I think I would share them if it were not for the fact that subsection 10(1) says that the licence is not transferable without the consent of the director. I think all you say would be true if we were saying licences are transferable. We would need regulations and all kinds of guidelines to deal with criteria.

What we are saying here is providing a window of opportunity. If I can speak from my own viewpoint, based on some of the things I have heard and some of the thinking I have done on the various patterns I would see these things getting set up under, and maybe I am bringing to bear a certain experience I have had, I think this allows some flexibility.

In your discussions of nonprofit/profit, I would draw your attention to subsection 2. That is indicating that the new applicant is to be treated under the same criteria the licence initially is. Again, that same preference for nonprofit exists.

Mr R. F. Johnston: If there is nobody else, I do not understand how that would work. In reality, when you have a nonprofit falling apart and you have somebody saying, "I am here as a profit organization to be transferred to," you are not in the same position as you are when you are calling groups forward.

Mr Carrothers: Because you are not guaranteeing the transfer in the first place. Just because there is somebody else there does not mean the transfer is going to take place. That is my point.

Mr R. F. Johnston: It is a question of onus.

Mr Carrothers: If the transfer were guaranteed, all you say would be true and I would be as concerned as you.

If we look at 3 and 4 again, we are dealing with no consideration being given for the transfer, no value to a licence. I would say to Mr Eves—he had the concerns—that someone here transferring a licence or whatever is really in no different position than a medical practitioner is when he does whatever he does. They cannot transfer a licence, but to some extent they transfer physical assets. I think they are in very much the same position, and this concept of goodwill being paid for does not really come to bear there either. I think that is an appropriate way to treat—

1550

Mr Eves: (Inaudible)

Mr Carrothers: To the extent that it does, perhaps it would also apply here, but the goodwill does not attach to the licence. The point I am making is that it seems fair to treat individuals the same. We are dealing with professional practices here and the places where those take place. I would really ask for support for this, because it covers off all the problems the committee is raising here and allows the flexibility we would all like to see as well.

Mr Reville: It appears that the majority of the committee is tending to what I think is an unfortunate direction, which raises this question: If the director refuses the transfer, what is the appeal process for that? Can someone answer that question? It is just being invented back there, I think.

Hon Mrs Caplan: There are motions Mr Eves has that are companion to this, which have been circulated, I believe. It is Mr Eves's amendment to section 19.

Mr Reville: I now see section 19, which suggests that there will be a hearing at the board, one of our two boards; I forget which one.

Interjection.

Mr Reville: Ah. Thank you.

The Chairman: Are we ready for the vote on Mr Carrothers's amendment to Mr Eves's motion? All those in favour? Opposed?

Motion agreed to.

The Chairman: On Mr Eves's motion as amended, are we ready for the vote? Shall the motion as amended carry? All those in favour? Opposed?

Motion agreed to.

The Chairman: I believe that concludes amendments to section 10. Any further discussion on section 10?

Mr Owen: I raise a point on the time. As you are aware, many of us were here to start at two o'clock. We were delayed for a number of reasons. I have a commitment. I have been trying to set up a meeting with certain ministry people about a problem in my riding. I have been trying to set it up for a month and today is the day. It involves a problem which cannot be dealt with after this week if I am not there. I think someone else is in a similar predicament.

The Chairman: As the chair, I am in the hands of the committee. A motion to adjourn is in order at any time.

Mr Owen: I would move that we adjourn at four o'clock. We are traditionally supposed to do so, as I understand.

The Chairman: Shall Mr Owen's motion to adjourn carry? All those in favour? Opposed? I guess it is carried. We adjourn at four o'clock.

Motion agreed to.

The Chairman: We will reconvene at 10 o'clock in the morning. We have four minutes for any procedural questions or business. We have not adjourned yet; hang on a minute. The motion was to adjourn at four, gentlemen.

Mr Reville: The amendment to section 12 is complementary to the amendment we just discussed. Why do we not move it and pass it?

The Chairman: Section 11: no discussion?

Mr Carrothers moves that section 12 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following subsection:

"(2) No person shall pay, transfer, accept or receive, in respect of a transfer of shares of a corporation that is a licensee, money or other

consideration that can reasonably be regarded as referable to the licence held by the corporation."

Mr Carrothers: That is a corollary type of penalty amendment we are adding to section 12, which matches what has been added to section 10, which deals with the question of perhaps those circumstances where a corporation holds the licence. This deals with the question of transferring the shares, clarifying that there shall be no consideration for the transfer of the licence paid when the shares are transferred.

Mr R. F. Johnston: The thing this whole move we are making here brings forward in my mind and in Mr Reville's mind is that this, instead of re-emphasizing the nonprofit nature of what we are involved with and hoping to develop in this field, is in a funny way going to be a means of really emphasizing the corporate sector. These kinds of amendments are going to lend themselves to corporations. The licence itself will be a loss leader. It will not be of that much interest to them, but in terms of corporate growth and corporate concentration, I have little doubt that this is an encouragement instead of just stopping transfers altogether.

Mr Carrothers: Can I comment?

The Chairman: The only thing is that we are approaching four o'clock, and I do sense a desire among—

Mr Carrothers: We have 60 seconds. I believe I can say what I have to say in 30, Mr Chairman.

The Chairman: I sense a desire among some committee members to find some way to carry on beyond four. Mr Eves has indicated—

Mr Carrothers: All right. Could I then move—

Mr Reville: We voted on that already.

The Chairman: We voted on it?

Mr Carrothers: What are we doing here? Let me comment on Mr Johnston.

The Chairman: All right. Go ahead.

Mr Carrothers: I think the amendments we just made to section 10 solve the problem you were just talking about, because one of the things that struck me about this bill was that if I were advising any client who came to me, I would say, "Set up your organization as a corporation because of the flexibility section 12 had." We have now added flexibility to section 10, which I think takes away from the stress on corporate structures for holding these licences. All this is adding in is a penalty provision making very clear that the same penalty that would be there if you are transferring a licence if it is held in a personal or partnership way would go to the corporation. So we are not changing anything. Actually, I think the concern you have was solved by the amendments we made to section 10 just a moment ago.

Mr Reville: You are talking very quickly. We know that is your argument; we just disagree with it.

Mr Carrothers: I am glad you gave me the opportunity to make it, then.

Mr Reville: The amendment to section 12 is difficult to support, because it flows from what you have just amended in section 10.

Mr Carrothers: I think it stands on its own. It is just a like amendment for the penalties.

Mr R. F. Johnston: It is permissive is what it all is—

Mr Carrothers: It does not say anything about transferability. It is a penalty provision only.

Mr Reville: That is right. It is no big deal, but what we are redoing is revisiting the original change of heart of the government, which originally said the licence shall not be transferred. Now you have said it may be transferred as long as you do not buy it.

Mr Carrothers: This would have been moved even without the changes to section 10. It stands on it own.

Mr Reville: You say. It would seem to be attached to the other amendment.

Mr Carrothers: Just by circumstance that we dealt with that one before this one. Numerical order.

Mr R. F. Johnston: You will be selling us land in Florida soon.

Mr Carrothers: I do not have any land in Florida that I would like to sell you. Mr Chairman, is it in order to move that we—to 4:30?

The Chairman: Let's take the vote on—

Mr Carrothers: Perhaps there is unanimous consent to do that, Mr Chairman, to stay in session till 4:30.

The Chairman: We did move to adjourn at four. Is there consent to stay until 4:30?

Mr Eves: The only point I would like to make is that I do have some problems and I have some amendments to section 18, which I suspect the government is not going to be willing to support. I have no qualms with dealing with section 12, which we are talking about now, sections 16 and 17, which flow from the amendment we made to section 10. If you want to clean those up up to the end of section 17 today, I am more than happy to do that.

Mr Carrothers: Why do we not do that, Mr Chairman?

Mr Eves: I am in your hands.

Mr Reville: Why do I not move that we do that? That means we have to revisit our previous motion and change it, so I move that we finish to the end of section 17. With apologies to Mr Owen who has now gone off to his important whatever: He did deliver a really good note to the committee and I think we should honour that.

1600

The Chairman: Is there agreement then to carry on till the end of section 17?



Motion agreed to.

The Chairman: Okay. Shall the amendment carry?

Motion agreed to.

The Chairman: Anything further to section 12?

The Chairman: Section 13: Any comments? Section 14: Any comments?  
Section 15: Any comments?

Section 16:

The Chairman: Mr Carrothers moves that subsection 16(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out "or after the death of the licensee" in the third and fourth lines and inserting in lieu thereof ", after the death of the licensee or after the licensee ceases to operate the facility."

Mr R. F. Johnston: Whichever comes first?

Mr Carrothers: Whichever comes first. This is an amendment really not dealing with the others, but dealing with the circumstance that did come to light that perhaps someone would simply abandon their facility and there was no remedial action the ministry could take. This adds that remedial action.

The Chairman: Discussion on the amendment?

Mr Reville: One wonders if this was something in your mind all along. This does not flow from the Eves entrepreneurial amendment?

Mr Carrothers: No.

Mr Reville: What a miracle.

The Chairman: Are you ready for the question?

Mr Reville: No. You have mentioned the Ministry of Education recently. I had a number of teachers who continued to teach after they were dead and—

Hon Mrs Caplan: As long as they paid taxes.

Mr Carrothers: Perhaps Mr Reville has land in Florida he is trying to sell us.

The Chairman: Are you ready for the question? Shall the amendment carry?

Motion agreed to.

The Chairman: Anything further on section 16?

Section 17:

The Chairman: Mr Carrothers moves that subsection 17(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following subsection:

"(ea) any person has paid, transferred, accepted or received money or other consideration, other than the prescribed fee, for the transfer of the licence."

Motion agreed to.

The Chairman: Anything further on section 17? We agreed to adjourn having completed discussion of section 17. Have we covered everything?

Mr Reville: I just wanted to give notice that on the morrow I shall be bringing forward an amendment that, if carried, would require the ministry to deliver an annual report on independent health facilities. I know that would be a big pain in the neck to the ministry.—

Mr R. F. Johnston: It might be onerous.

Mr Reville: It would be onerous, but in these days of desktop publishing the minister could probably do it herself.

Hon Mrs Caplan: We did not talk about it during estimates.

Mr Reville: Your estimates are coming up in 1999 as far as I can tell.

Mr R. F. Johnston: The days of estimates are long gone.

The Chairman: We agreed to adjourn after having completed section 17. We will meet again at 10 o'clock.

The committee adjourned at 1606.



CARON  
XC 12  
-578 ..

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

INDEPENDENT HEALTH FACILITIES ACT, 1989

WEDNESDAY 30 AUGUST 1989





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Neumann, David E. (Brantford L)

VICE-CHAIRMAN: O'Neill, Yvonne (Ottawa-Rideau L)

Allen, Richard (Hamilton West NDP)

Beer, Charles (York North L)

Carrothers, Douglas A. (Oakville South L)

Cunningham, Dianne E. (London North PC)

Daigeler, Hans (Nepean L)

Jackson, Cameron (Burlington South PC)

Johnston, Richard F. (Scarborough West NDP)

Owen, Bruce (Simcoe Centre L)

Poole, Dianne (Eglinton L)

Substitutions:

Eves, Ernie L. (Parry Sound PC) for Mr Jackson

Keyes, Kenneth A. (Kingston and The Islands L) for Mr Owen

LeBourdais, Linda (Etobicoke West L) for Ms Poole

McClelland, Carman (Brampton North L) for Mr Beer

Reville, David (Riverdale NDP) for Mr Allen

Clerk: Decker, Todd

Staff:

Spakowski, Mark, Legislative Counsel

Tucker, Sidney, Deputy Senior Legislative Counsel

Witnesses:

From the Ministry of Health:

Caplan, Hon Elinor, Minister of Health (Oriole L)

Sharpe, Gilbert, Director, Legal Services Branch

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 30 August 1989

The committee met at 1018 in committee room 1.

INDEPENDENT HEALTH FACILITIES ACT, 1989  
(continued)

Consideration of Bill 147, An Act respecting Independent Health Facilities.

Section 18:

The Chairman: The committee will come to order. We are considering Bill 147, An Act respecting Independent Health Facilities. We are going through clause-by-clause with the procedure we have agreed upon and we are beginning today with section 18. Does the minister have any comments on section 18?

Hon Mrs Caplan: No comments.

The Chairman: I do not see any request for general discussion of section 18, so Mr Eves, would you move your amendment.

Mr Eves: As we discussed two days ago—I will not belabour the point again—I am going to move an amendment to section 18 to strike out subsections 18(4), 18(4a) and 18(4b) and replace them with a subsection 18(4) that will give the same appeal powers for anybody from a decision by the minister as is elsewhere in the act for other decisions. That would be as opposed to being able to appeal to the Lieutenant Governor in Council. The appeal process would be the same; that is, to the board and then on to the Divisional Court.

The Chairman: Mr Eves moves that subsections 18(4), 18(4a) and 18(4b) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"(4) A notice under subsection (3) shall inform the licensee that the licensee is entitled to a hearing by the board if the licensee mails or delivers, with 15 days after the notice under subsection (3) is served on the licensee, notice in writing requiring a hearing to the director and the board, and the licensee may so require such a hearing."

Mr Eves: I am doing this to make the appeal process throughout the act consistent with subsections 17(4) and 19(2). Members of the committee might also know, because the ministry has indicated on previous occasions, that there are other places where similar decisions by ministers are appealable only to the Lieutenant Governor in Council. I would point out that the appeal process I am recommending is exactly the same as in the Nursing Homes Act of Ontario.

Mr Carrothers: I was going to point out that there is already in the legislation as it is written an appeal to the Lieutenant Governor in Council. What we are talking about here is the minister's discretion, questions of policy and that sort of thing, and normally they are not appealable by this

type of route. The other appeals in the act are appeals of the exercise of discretion of the director, for which I think it is appropriate to go down the route to the board, but in the case of a ministerial one, I think the only appropriate appeal is to cabinet. Therefore, I cannot support this amendment.

Mr R. F. Johnston: The only appropriate appeal is to God herself afterwards.

Mr Carrothers: Ultimately, perhaps that is where all is appealable. We do not deal in that particular jurisdiction here.

Mr Reville: I just indicate that I will support my colleague from the Progressive Conservative Party.

The Chairman: Shall Mr Eves's amendment carry? All those in favour? Opposed?

Motion negatived.

Section 19:

Mr Eves: I have another amendment to section 19, seeing as how we got into the whole concept of transferring licences yesterday and my amendment, as amended by Mr Carrothers, was adopted by the committee. Let's make this a workable amendment.

The Chairman: Mr Eves moves that section 19 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following subsection:

"(8) Subsections (1) to (6) apply with necessary modifications where the director proposes to refuse to consent to the transfer of a licence and, for the purpose,

"(a) the director shall serve notice under subsection (1) upon both the licensee and the proposed transferee; and

"(b) the licensee and the proposed transferee, or either of them, may require the hearing by the board, but if they each require such a hearing, the board shall combine the applications into one proceeding."

Any comments, Mr Eves?

Mr Eves: None other than the ones I have already given. This will make this consistent on the occasion of a transferee or a proposed transferee of the licence.

Mr Carrothers: I might indicate that it does indeed fall out of what was done for changes to sections 10 and 12, so we will be supporting it.

Motion agreed to.

Section 20:

The Chairman: Any comments?

Hon Mrs Caplan: No comments.

The Chairman: I do not have any amendments before me. We will move along to section 21.

Section 21:

The Chairman: Any comments?

Hon Mrs Caplan: No comments.

The Chairman: We have a Conservative amendment by Mr Eves.

Mr Eves: I have an amendment to section 21, as committee members are aware; two amendments actually, subsections 21(1) and 21(5). During the course of the hearings, there were numerous delegations that appeared before the committee which requested that through the appeal process, if you made an appeal and the board heard your decision and then you went on, the matter was appealable only on questions of law in the way the act is worded. Several delegations and individuals who appeared before the committee expressed some concern about that and requested that it be appealable on questions of law or fact or both.

The Chairman: Mr Eves moves that subsection 21(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"21(1) Any party to proceedings before the board may appeal from its decision or order to the Divisional Court on a question of law or fact or both."

Mr Carrothers: What is happening with this amendment, if it goes through, is that you are creating a whole new trial at the Divisional Court. I think you are creating a very time-consuming and very expensive process that would then be available in every circumstance and bog the system down even worse than it is.

Normally, appeals are only on questions of law. That is the way the court system works. Once the facts have been determined at the first level, they are not generally appealable unless there have been definite mistakes. I think those who have worked in the administrative area know that you can piggyback very outrageous fact problems like those Mr Eves is concerned about into an appeal on law in any event, because the whole thing becomes so distorted. I certainly cannot support this amendment.

Mr R. F. Johnston: It is a bit onerous.

Mr Eves: The only comment I would have about that, again, is that this is the same appeal process that is in the Nursing Homes Act of Ontario.

Mr R. F. Johnston: Oh, well, I guess we will have to get that amended then.

Mr Reville: We could stay in session for ever.

The Chairman: Mr Eves amendment is before us. All those in favour? Opposed?

Motion negatived.



Mr Eves: I am going to withdraw the amendment for subsection 21(5). We have already been defeated on that issue.

Section 22:

The Chairman: Any comments?

Hon Mrs Caplan: No comments.

Section 23:

The Chairman: Mr Carrothers moves that section 23 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"23. The minister may pay all or part of any one or more of the capital costs of an independent health facility, the operating costs of an independent health facility or the costs of the services provided in an independent health facility according to whatever method of payment the minister may decide upon."

Mr Carrothers: The purpose of this amendment is to make it very clear that some consideration for capital can be included in the facility fee and is in fact responding to concerns raised at the hearings.

Mr Reville: This amendment is in line with the government's intentions as set out in the fact sheet and in the discussion. It is an amendment that I guess we have all been expecting. The only concern I have is that to the extent that for-profit operations are funded, it would seem an inappropriate use of public moneys to provide capital in those connections, although we will presumably see how that goes.

The other comment I have is, has it become our practice to leave dangling prepositions in our legislation?

Mr Carrothers: Perhaps we could ask that of legislative counsel.

Mr Reville: It is the sort of thing up with which some people will not put. You know that.

Hon Mrs Caplan: How about "may decide"?

The Chairman: "Upon which the minister may decide."

Mr Reville: I do not care. I was just being a bit of a jerk, actually.

The Chairman: I am glad you raised it because I was going to.

Hon Mrs Caplan: Is there not a normal motion at the end of committee hearings that legislative counsel make sure the grammar is correct?

Mr Tucker: The only comment I would make is that we are becoming less formal these days in all writings. I suppose it is something to do with plain language writing. If it flows easier, we do not worry too much today about things like split infinitives and dangling participles, as long as the language is clear.

Mr Reville: Oxford will be spinning in its grave.

Hon Mrs Caplan: It is nice that you noticed.

The Chairman: So wrong grammar is acceptable plain language.

Interjection: Incorrect grammar.

Mr Tucker: The grammar that was required many years ago is not necessarily the grammar of today.

The Chairman: You are right. The language is flexible, fluid.

Motion agreed to.

1030

Section 24:

Mr Carrothers: I have a number of amendments. Shall I move all three of them at once? I guess they are part of subsequent sections as numbered in the bill.

Mr Reville: On a point of order, Mr Chairman. Mr Eves has an amendment that precedes yours.

Mr Eves: Are we talking about section 24 now or sections 24a, 24b, 24c, 24d, the different sections?

The Chairman: Do you have an amendment?

Mr Eves: We are just going to deal with section 24 itself right now. Is that right?

The Chairman: We are on section 24 right now.

Mr Eves: If I may beg the committee's indulgence for a minute, I would like the ministry to run through the scenarios of how they see all these sections, from section 24 through to section 24e and indeed sections 25 and 26, working because I am somewhat concerned. I have a series of amendments that I have just tabled with the clerk which I am not sure I am going to move, but I may move, which basically just strikes out sections 24a, 24b, 24c, 24d and 24e. They also strike out certain sections of section 26.

The reason I was contemplating moving those motions or amendments is that those are all sections that were added subsequently by the ministry when the bill was redrafted or reprinted and there seems to be some confusion.

Originally, the bill started out with the intent, I believe it has been said on several occasions, that it was only going to apply to physicians. Then there were some concerns about being able to inspect a health facility, the health facility being different of course than an independent health facility. Then there were some concerns about expanding those parameters to include other health professions or health occupations.

As I said when we first dealt with section 1, I would much prefer a broad approach that would make the bill applicable to all instances in the future. I believe that when we have discussed parts of sections 24a, 24b, 24c,

24d and 24e in the past, the ministry has indicated that while it had several amendments it was prepared to move with respect to sections 24b, 24c and 24d, it would have to wait until the health professions legislation review was completed before it could really say what it wanted to say in those sections of the bill. If I am misstating the fact, I invite the ministry to correct me.

I am a little concerned that this is a fairly haphazard approach to dealing with what could be a very significant issue or matter in the future. I would like to deal with it in the most all-encompassing way possible. As I stated when we debated section 1, my preference would be to amend section 1, to amend those various definitions and make it apply to any and all bodies of health professionals that may be included in the act in the future.

The majority of the committee chose not to adopt that line of reasoning, but I really think we are trying to plug little holes but are not really plugging them all, and we are not really sure if we know what we are doing and we will not really know until we have the HPLR legislation through.

I really do not think that is a very good way to pass a significant piece of legislation. I prefer to wait until the HPLR legislation is through and then go back and amend this act. Trying to amend it now, as the ministry is attempting to do with sections 24a, 24b, 24c, 24d and 24e, we will come back and revisit it and fill in the gaps later.

Those are my comments. I stand to be persuaded that they are not very valid ones. I would like to hear what the ministry has to say.

The Chairman: I think the minister would like to refer to our health law expert.

Interjections.

Mr Eves: Did Richard Johnston make that sign?

Mr Sharpe: It would be nice if it were properly printed for future committees.

Hon Mrs Caplan: We will try to print it for future committees.

Mr Sharpe: Does that go along with my ability to wear a sweater next time?

I will run through the sections, beginning with section 24. I did indicate on Monday that because of the number of amendments made after consultation with groups like the College of Physicians and Surgeons of Ontario it was necessary to completely restructure these provisions from the bill. It is a bit convoluted, but I think it does make some sense. I will try to take you through it sequentially.

Section 24 is the only place where the minister is appointing a government person to do inspections. Subsection 24(3) limits the role of those inspectors to licensed facilities. This is similar to other statutes the government has where we have licensed premises, nursing homes, for example, labs and so on, where the government has a responsibility to ensure that the premises it licenses meet certain conditions and standards of the licence, to inspect the physical plant and other things within the facility. Subsections 24(1) and 24(3) are just the government inspectors looking at government-licensed facilities.

Section 24a is where we begin to get into the role of the college and some of the other groups. Subsection 24a(1) deals with enforcement of the act. It deals with having reasonable grounds. Of course, that has a certain weight in law; reasonable and probable grounds is something that is well defined in the various precedents and so on. Where reasonable ground to believe there has been an offence committed exists, there is the ability to go outside the licensed facilities and look at some of these unlicensed places, like, for example, the office of a doctor who might be improperly charging facility fees, to see if that is being done.


This was one of the fundamental changes made to the bill because of input from a number of avenues, and this requires the director to give notice to the registrar of the college. The college of physicians and surgeons is the only group that can now go and look at these unlicensed places. That is the operation of section 24a. It spells out that the director gives notice to the registrar, the registrar then does certain things and appoints people to make inspections and those inspectors go out and look at these other places.

Mr. Eves: Before we move on, could I try to clarify a couple points? You say section 24a requires the director to give notice. I brought this point up once before, but perhaps you can reiterate it. The section reads, in subsections 1 and 2, as I read it, "The director may give notice to the registrar of the college." It does not require him; it says, "may." There is a difference, in my mind anyway. I gather this subsection is only applicable to physicians and to the Ontario college of physicians and surgeons. Is that right?

Mr. Sharpe: It is applicable to any place where health care is delivered to patients and ultimately, if other groups were operating independent health facilities, could involve inspection of unlicensed premises run by those other professional groups as well. Certainly the thrust of this bill now would involve essentially looking at services provided by doctors, because those are the only things that qualify insured services within the scope and the exemptions that the government is proposing.

Mr. Eves: The problem I have with that is that if you intend that this section will cover people other than physicians, I would suspect that some of those other health professionals are not going to be too happy if the college of physicians and surgeons is the one that appoints somebody to go out and inspect their facility. That is one of the problems.

The note I made in the column of my bill was, "Why only doctors' offices?" Is this only going to include facilities run by physicians, or could it include other health professionals? If it includes other health professionals then the definition you have of the college only talks about the college of physicians and surgeons, and I do not know if those other health professionals are going to be too excited about the college appointing health inspectors to look at their operations.





1040

Mr Sharpe: If I could respond, what I indicated on Monday when we went through some of this was that the current concept of the bill was that doctors providing insured services would be the ones who were examined. That is why the college of physicians and surgeons is there up front.

Once the health professions legislation review is complete and a separate special status will be accorded to other professionals with proper governing bodies and so on, it is to be expected that a complementary amendment to that whole package will be made to section 24a to broaden the scope if it is considered appropriate at the time by the government and ultimately by the committee.

It is just that it is premature now to permit other governing bodies to be involved in these kinds of inspections, because it is just physicians' services in the community that we are talking about now. Many of the groups—I was going to mention something when we come to subsection 24b(3)—do not really have formalized mechanisms such as the groups do have under the Health Disciplines Act, and a number of other professional groups that ultimately, with the health professions implementation, may be brought in. But until we see how that package unfolds, I think it would be very risky, because this is a very heavy inspection power of unlicensed places, to open it up to anyone other than the college of physicians and surgeons.

Mr Eves: If that is the case, as I understand it the college of physicians and surgeons already has the ability, if it thinks a physician is doing something improper, to go in and inspect that particular physician's operation. If I am wrong about that, then you can correct me about that. If that is the case, and if this section is only purporting to deal with physicians for the time being and you are going to amend it when the suitable time comes, why would you not just leave well enough alone until the HPLR legislation goes through and deal with the whole thing then?

Mr Sharpe: I think the problem is that normally the college of physicians and surgeons would only get involved if there were a complaint lodged. Then they have the power, if they think there is some basis to it, to investigate the doctor's practice and to look at matters relating to their jurisdiction that have to do with professional misconduct as set out in the regulations.

This is a mechanism that enables the college, at the request of the director, to look at doctors' offices in circumstances that are somewhat different from the grounds that it would currently be looking at. The circumstances would not require a complaint from a patient here; it would be the director having reasonable grounds to believe. Then the director would trigger a mechanism where the college inspector would go out, have a look and determine whether there has been an offence under this act. It is not within the current scope of the college to do these sorts of things easily.

Mr Eves: Is there any set of circumstances in which the director can do this without going through the registrar of the college?

Mr Sharpe: No, there is not.

Mr Eves: Then why is the word "may" in there instead of requiring he do it?

Mr Sharpe: This was discussed with the college: "may" rather than "shall" is your question, as I understand it. If there are events that lead the director to believe there may have been an offence, and if the circumstances were there to enter into negotiations with the clinic—it might be, for example, a question of an illegal operating room that might have been brought to the director's attention—the director can make inquiries on his or her own behalf, discuss things with the person running the operation and perhaps work something out without necessarily having to formally involve the college and that entire mechanism and what that involves.

If we have a "may," it permits the director to seek less severe means of working things through than formalizing the process of bringing the college into it in every case. I think the understanding is that in circumstances where that is not possible, certainly the director will have to turn to the college. There is no other option. The "may" does not suggest that the director can somehow appoint an inspector, a government bureaucrat. That is not permitted under the statute. It is just there to provide flexibility.

Section 24b deals with the appointment of assessors and the process by which that can be done. I believe during the submission of the college of physicians and surgeons that there was an explanation given of how the college is more and more becoming involved in developing standards of practice, looking at matters of continuing competence of physicians and doing assessments of the kind of quality of service that physicians are delivering in their offices.

The notion under subsections 24b(1) and 24b(2) is that the college, either through the registrar or its council, can on its own have an ongoing system of assessments that would allow it on a regular basis to ensure the quality of care in various clinics without necessarily having to rely each time on the director requiring that the assessment be done.

The provision in subsection 24b(3) is the case where the director wants assessments to be done. It may be special circumstances or it may be regular assessments. It is a parallel provision to subsections (1) and (2). It is in this section where the government amendments begin to come in. This is where the broadening of the concept of the groups that can do assessments comes in. If the concept of "registrar" or "college" were broadened to include all of these other groups and all of these governing bodies, then in subsection 24b(1) you might have circumstances where any group, a so-called fringe group, might on its own appoint an assessor who has all sorts of powers under this act.

What subsection 24b(3) allows, with the proposed amendment, is that where the director decides that quality assurance assessments are necessary and a multidiscipline clinic is in operation, the director can bring in not only the college of physicians and surgeons, but under the proposed amendment the chief administrative officer of the governing, registering or licensing body of any health profession. This is where the multidisciplinary approach would come in.

Similar amendments are proposed in section 24c and section 24d. But essentially what these provisions relate to is the mandated—I say "mandated" because the requirements of a licence involve showing the government how the clinic will ensure ongoing quality assurance and measurement of outcome and so on. This intricate scheme in sections 24b, 24c and 24d of quality assurance, appointment of assessors and so on will enable the director to control the process where there will be ongoing, regular quality assurance reviews by

physicians. Where other disciplines are involved—for example, nurses or other groups—then the College of Nurses of Ontario could be brought in or any other professional group that the director sees as being necessary in mandating independent assessments.

Mr Eves: Can this only be done, though, through the college of physicians and surgeons, regardless of what other profession it is? Section 24b, for example, refers to the registrar. The registrar is defined as the registrar of the college.

Mr Sharpe: This is where I was distinguishing between subsections 24b(1) and (2) and subsection 24b(3). Under subsections 24b(1) and (2) only the college of physicians and surgeons on its own initiative can appoint assessors on a regular basis without involving government or the director or anything. The reason it is being suggested that this be left to the college of physicians and surgeons is that in the submissions made, it is the primary group that has indicated an existing program and an expanding program to do quality assurance reviews of members of its profession.

It may again be the case that when the health professions legislation package is ready to proceed and a number of other groups have adopted a model, perhaps like the college of physicians and surgeons uses, or its own version of that model, subsections 24b(1) and 24b(2) could be expanded. But for the time being, it is being proposed that under subsection 24b(3), with the control of the director triggering reviews by other professional groups—it could be any other professional group under subsection 3—the director will have control when they are brought in. It is the intention—my understanding of why that is being expanded in the motion under subsection 24b(3) is to give flexibility to the director to allow for the bringing in of other disciplines.

That is the distinction between subsections 1, 2 and 3. Under subsection 3 the director will have the authority currently to bring in all other disciplines as required, depending on the multidisciplinary delivery of health services in a broad-range clinic.

1050

Mr Eves: While you are on that, can you walk us through sections 25 and 26, especially 26?

Mr Sharpe: Section 25, of course, sets out the function of the assessor. Subsection 1 discusses, as it says, that they must carry out assessments of quality and standards in licensed facilities. Then subsection 2 makes it a condition of the licence to co-operate with the assessor and so on.

Section 26 is the inspection power in relation to the registrar of the college of physicians and surgeons. In other words, section 26 would refer back to subsection 24a(1). In other words, the director has given notice to the college that there may be a problem with someone offending section 3 of the act. The registrar in the section 24 process appoints an inspector. The registrar's inspector then can enter premises of a health facility, broadly defined, which would include doctors' offices, to make an inspection under clause 26(1)(a) only in respect of whether there has been a contravention of section 3.

Section 3 is the provision saying you cannot operate an independent health facility without a licence. You cannot bill patients facility fees unless you are an independent health facility. It is only for that purpose

that the registrar, and only the registrar, not the government, could send someone into an unlicensed premises.

Clause 26(1)(b) provides an enhanced role for a year to the registrar of the college to the grandfathered facilities to allow for ongoing reviews during that year to make sure they are in compliance with certain standards.

Subsection 26(1a) permits the minister's inspector to take a look at independent health facilities. These are licensed places, and this is what I said earlier. The minister is appointing inspectors to look at licensed places to make sure that they are in compliance with the act in the terms of their licence. That is expected of any government-licensed place, that the government, like the nursing homes inspection branch, will have inspectors who ensure compliance with the act and the condition of licences.

The other subsections go through the various powers and so on and simply are complementary to the mechanism I have just described.

As I say, it is a bit convoluted, and as I explained, the primary reason for that is that substantial amendments have been made between second reading and the present, given the many representations made by so many of the groups. I am hoping that it does clarify. We have developed a kind of a map scheme, a schematic diagram to take you through it. If you want, we have that available.

Mr. Eves: No, that is not necessary.

Mr. R. F. Johnston: Oh, come on, Ernie.

Mr. Eves: Do you want to—

Mr. R. F. Johnston: No.

Mr. Eves: On good faith, I guess I am not going to move the amendments to strike out those sections a, b, c, d and e.

Mr. Reville: Does that mean we withdraw this package?

Mr. Eves: That means we are withdrawing this package.

Mr. R. F. Johnston: If only we had known in time to save the forest.

Mr. Eves: The government may wish to proceed with its amendments.

The Chairman: Thank you, Mr. Eves. Is there anything further on section 24? Section 24a, then; anything on that? Section 24b, Mr. Carrothers.

Mr. Carrothers moves that section 24b of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out subsections 3 and 4 and substituting the following therefor:

"(3) Where the director considers it necessary or advisable that assessments be carried out of the quality and the standards of services provided in a health facility referred to in subsection 26(1a), the director may give notice in writing to the chief administrative officer of the governing, registering or licensing body of the health profession or to the licensee or operator of the health facility.



"(4) The director is not required to give notice to or consult with the licensee or operator of the health facility before giving notice to the chief administrative officer of the governing, registering or licensing body of a health profession."

Motion agreed to.

Section 24c:

The Chairman: Mr Carrothers moves that section 24c of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"(1) Upon receipt of notice under section 24b, the chief administrative officer of the governing, registering or licensing body of a health profession shall appoint one or more persons in writing as assessors.

"(2) The chief administrative officer shall report to the director upon the officer's appointments of assessors under subsection 1 and upon the assessments made by them.

"(3) The chief administrative officer shall make the reports at such times, in such form, in such detail and with such supporting material as is required by the director."

Motion agreed to.

Section 24c agreed to.

Section 24d:

The Chairman: Mr Carrothers moves that section 24d of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by striking out subsection 5 and substituting the following therefor:

"(5) If the director and the licensee or operator do not agree upon the person or persons to be appointed, the director may give notice to the chief administrative officer of the governing, registering or licensing body of the health profession under section 24b."

Motion agreed to.

Section 24d agreed to.

The Chairman: Section 25, discussion?

Section 26, Mr Reville?

Mr Reville: No, I do not have anything to say at all.

The Chairman: Okay. Section 27?

Anything on section 28?

Mr Reville: Excuse me. On section 26 there is a Tory motion.

Mr Eves: We withdrew that.

The Chairman: It is withdrawn.

Mr. Reville: I thought you withdrew the section 24 amendments. I am sorry.

Interjection.

Mr. Reville: I just want to cover for my friend here.

The Chairman: Okay, good. I believe we are up to section 27. Anything on section 27? Section 28? Section 29? Section 29a?

Section 30:

The Chairman: Mr. Carrothers moves that section 30 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"(1) In this section, 'confidential information' means information obtained by a person employed in the administration of this act or making an assessment or inspection under this act in the course of that person's employment, assessment or inspection and which relates to a patient or former patient of the health facility.

"(2) No person shall communicate confidential information to any person except in accordance with subsection 4.

"(3) Subsection 2 applies to any person whether or not that person is or was employed in the administration of this act or is or was an inspector or assessor under this act.

"(4) A person employed in the administration of this act, an assessor or inspector under this act or any person who obtains confidential information pursuant to this subsection may communicate confidential information,

"(a) in connection with the administration or enforcement of any act or any proceedings under any act;

"(b) in connection with matters relating to professional disciplinary proceedings, to a statutory body governing a health profession;

"(c) to that person's counsel; or

"(d) with the consent of the patient or former patient to whom the information relates.

"(5) No person employed in the administration of this act or who made an inspection or assessment under this act shall be required to give testimony in a civil action or proceeding with respect to any information obtained in the course of that person's employment, assessment or inspection except in a proceeding under an act or a regulation under an act.

"(6) A provincial offences court may exclude the public from proceedings to enforce any act if the court is of the opinion that confidential information may be disclosed of such a nature, having regard to the circumstances, that the desirability of avoiding disclosure of that information in the interests of any patient or former patient to whom it relates outweighs the desirability of adhering to the principle that hearings be open to the public."

1100

Mr Carrothers: This is an expansion of the confidentiality provisions which were contained in the bill as proposed to be amended, resulting from some of the discussions. It contains some very significant extensions, particularly as they relate to people who might come in contact with information but who were not the ones actually doing the inspection.

Mr R. F. Johnston: We had a brief discussion of this matter when it was first brought to our attention a few days ago. I am wondering if the government has had any feedback as yet on the provisions in the first new part which basically adds the new powers, which would seem to go farther than any other legislation at this stage. Have you had any reactions at all from groups which might be affected, whether it is from the media, press council-type people or civil liberties-style people? I mean, it has not had any play, so maybe people are not even aware of it as yet, but I just wondered if you have had any legal reactions or anything to this initiative.

Mr Sharpe: If you like, we have not had any formal reactions to it but for some years, in the context of amendments to the Mental Health Act, we attempted to do this in 1978 in the Mental Health Act. We have a statement there in section 29 that says "No person shall disclose." When I have done educational sessions on the Mental Health Act, I have tried to make the argument that any person who receives information on a psychiatric history must be under the same obligation, but unfortunately it is not clear in the Mental Health Act.

It is a records provision and it is not really an information provision. I think we would have trouble prosecuting someone under that act. A number of the patients' rights groups for some years, in terms of our crafting an omnibus confidentiality statute, have made it clear that it is going to be fundamentally important to extend that kind of protection to anyone who receives confidential patient information. While we have not discussed formally this provision in this bill, the principle has been debated for some years.

Mr R. F. Johnston: What about the second half of it in terms of the court being a closed approach and the onus of it, because of Supreme Court rulings, as you said, being open unless it can be shown that that is going to be so detrimental? Given that situation and given the sensitivity of some of these procedures that might be involved, just taking the abortion example in particular, is there anything that might be added to what you have put in at this point that would allow judges to request that there not be reporting of the procedures?

This says it may be an open or closed case and the onus is basically on its being open until otherwise proven. I am not a legal expert, obviously, but even if it were to be open, are there other provisions which can allow a judge at this stage to say, "Yes, this will be open, but this sort of information within what we are talking about will not be"?

Mr Sharpe: My understanding of this is that it is not an inherent jurisdiction kind of court versus provincial offences. If it is a provincial court, you look through its statute to see what its enabling authority is. But we looked at a number of options and frankly the question of an ability to make a nonpublication order was seen an alternative to just closing the hearing entirely. We looked at the Statutory Powers Procedure Act which I indicated will apply to the tribunals under this act. There the notion is that

a hearing shall be open to the public except where the tribunal is of the view that intimate personal matters will be discussed. You weigh that against the desirability that it be open. Of course, if it is closed, the press could not get in at all.

We took a look briefly—and in light of some of the recent Supreme Court of Canada decisions I do not know how this would stand up—at the federal Immigration Act, which says that an inquiry by an adjudicator shall be held in camera. That is "shall be held" with certain exceptions. So that is closed and you can open it.

I suppose we could provide additionally that for an open hearing a nonpublication order could be made; but I would think if the criteria are satisfied for the concern about the intimate personal nature of the information, one would close the hearing. It might be a similar test to nonpublication, which was ultimately used. I cannot honestly provide an authoritative opinion on that aspect of it.

Mr R. F. Johnston: I wish I were sure that was the case, but I can really see, because of the Supreme Court ruling, a judge feeling, "There is a lot of sensitivity here, but boy, this is an important issue; there is a public accountability here that is fundamental and I must open the court for this."

On the other hand, if he were given the power, he might say, "I will open this court, but on these several matters I will allow you to bring these records before me first and I will tell you which of them I think can be withheld and which cannot be withheld." I just do not know if that is possible or not; maybe it is fine-tuning that you can do afterwards, but I just worry about where this is all ending up in the long run.

Mr Sharpe: We have two draftsmen here and certainly in principle it does make a lot of sense. Perhaps if we could come up with something that the committee could look at. I think you would have to have criteria again, but you could use similar criteria and say that even where the hearing is open, the court can make a nonpublication order based on the same criteria.

Mr R. F. Johnston: I would be interested in that. If you think that is possible, I would be interested in seeing that.

Mr Tucker: Probably such a provision could be drafted. The question is whether it would be practical, or whether it would work very well in practice, to go through a trial and say, "We say you cannot print this and we say you can print that." I have difficulty imagining a trial actually proceeding in that manner. I think in practice the hearing is either going to be open or it is going to be closed. It is not going to be some sort of a hybrid. I just do not see how a hybrid would work very well. That is my personal opinion of it. Certainly, I suppose we can draft anything that the committee wants and have a look at it.

Mr R. F. Johnston: I do not disagree with you at this stage of the analysis of where things are at at the moment, but as things are evolving now in this whole matter of openness or closed nature, the pendulum seems to have swung fairly strongly now towards things being presumed to be open.

Given the nature of some of the things that will come out of what we are doing here, I am wondering if there are other options open to judges. Maybe some individual judges would prefer a hybrid to having to make the hard-line



decision against the interests of a woman who has undertaken an abortion, for instance, or a number of them, who may have a particular facilities case, but because he or she feels the obligation to have that case open and may feel that there is some sort of control over certain kinds of records that he or she would not wish to be brought forward.

What you are saying is you cannot make it a hybrid, but if somebody wished to, I would sure rather they had that option to do it than to have just straight black or white in this, given the pain that can come out of it.

Mr Tucker: You realize, Mr Johnston, what you are suggesting is that the press will not be able to publish it, but the rest of the town will know.

Mr Daigeler: That is right.

Mr Tucker: The public would be able to enter the courtroom and sit and listen.

Mr R. F. Johnston: That is true. Of course, you can do that in young offenders' court too.

Mr Eves: I believe when Mr Linden appeared before the committee he raised the whole issue of confidentiality. Although I would have preferred to have seen the proposed omnibus bill by the government as opposed to trying to approach it in this fashion, I will be supporting the proposed government amendment with respect to section 30.

I had a personal inquiry of my own that perhaps Mr Sharpe would like to comment on with respect to subsection 6 and the words "any act" as opposed to "this act."

Mr Sharpe: Again, the notion is that we are trying to extend the effect of this protection as broadly as possible. There is at least one case I am aware of now involving the Health Disciplines Act in an appeal in terms of whether a disciplinary hearing should be open or closed. This creates some concerns. What if, for example, a college inspector goes into a doctor's office and sees information that is important information in relation to the poor quality that doctor is providing to his or her patients, takes the information away and then attempts to use the information under the Health Disciplines Act, and the hearing may be opened. We are concerned. We do not want whatever proceeding under any act may fall out from obtaining the information under this act to reveal very confidential information.

1110

Our initial draft was under this act and we changed it to "under any act" because we realized that the college might decide to proceed against a doctor and we do not want that hearing to be open if it is very intimate, personal information.

The Chairman: Mr Reville?

Mr Reville: I will pass.

The Chairman: Anyone else?

Mr R. F. Johnston: This is my comment. Rather than trying to draft something at this moment, I would rather leave it with the ministry if it

thinks it can fine-tune this somewhat. There will be another option, which is committee of the whole House, if you choose, and I would welcome seeing it. I just wanted to flag what I see as an evolution of this which could be quite detrimental especially to women in the court system, which would really bother me, given some of the ways that courts have been dealing with women lately.

The Chairman: The minister would like to comment in response.

Mr Reville: Those judges got fired.

Hon Mrs Caplan: I think the issues that are raised in this legislation and the discussions around provisions of confidentiality, protection of personal privacy and the public interest in being able to ensure quality are the kinds of issues which we will have the opportunity to discuss in the broader context of all of the other pieces of legislation.

What we have attempted to do in this bill is use this opportunity to state the principles. Those same principles, if acknowledged and accepted here, will then allow us to take a consistent approach in addressing other pieces of health legislation in a more comprehensive fashion.

One of the things that I say regularly is that perfect takes a little longer. I believe that what we have here goes farther than any other piece of health legislation that is in place today. It also enshrines principles which we know we want to have in place so that people can have the kind of confidence that during quality assurance reviews we do everything we can, within the confines of legislative drafting, to ensure that those concerns are properly addressed.

I think the work of this committee and the issues that have been raised through the committee process in fact have helped us to draft the kind of provisions which I think will set the stage for future discussions.

Motion agreed to.

Section 31:

The Chairman: Mr Carrothers moves that subsection 31(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by inserting after "3" in the first line "10."

Mr Carrothers: That is just a complementary amendment to things we have done previously.

Motion agreed to.

The Chairman: Mr Carrothers further moves that section 31 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following subsection:

"(6) Every person who is guilty of an offence under this section for contravention of section 10 or subsection 12(2) is liable on conviction, in addition to any fine under subsections 4 or 5, to a fine not exceeding the amount of money or the value of the consideration paid, transferred, accepted or received in contravention of section 10 or subsection 12(2)."

Motion agreed to.

Section 32:

The Chairman: I believe there is an amendment by Mr Reville.

Mr Reville: There is, a new section.

The Chairman: It will be section 32a then. Is there anything on section 32 as printed? Then we can proceed with Mr Reville's amendment.

Section 32a:

The Chairman: Mr Reville moves that the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following section.

"32a. The minister shall annually prepare a report on the operation of this act and submit it to the Lieutenant Governor in Council and shall then lay the report before the assembly if it is in session or, if not, at the next ensuing session."

Mr Reville: Mr Chairman, I beg leave to further amend my amendment by striking the word "operation" and inserting in lieu thereof "implementation." "A report on the implementation of this act," is how it will now read. You have heard already my arguments about why I think an annual report is a good idea. I think it will be helpful to the government. It will be helpful to the opposition. It will allow us to discuss, if the Legislature so chooses, how well this is working, and it seems to me to be an appropriate kind of request to make.

The Chairman: The amendment moved by Mr Reville then is as printed with one change, the word "operation" being changed to "implementation."

Mr Carrothers: I appreciate Mr Reville moving the amendment I was going to move, and I believe that I can support this amendment as amended.

Mr Reville: Very well done.

Mr Eves: I think that Mr Reville's section makes eminent sense.

The Chairman: Shall the amendment carry?

Motion agreed to.

Section 33:

The Chairman: Section 33, Mr Carrothers.

Mr Carrothers: It is Mr Eves, I believe.

Mr Eves: Mine is just slightly before Mr Carrothers'. This again arises out of including the concept of the transferring of licences. We are just slightly changing the wording in paragraph 5.

The Chairman: Mr Eves moves that paragraph 5 of subsection 33(1) of the bill as set out in the reprint to show amendments proposed by the Minister of Health, be struck out and the following substituted therefor:

"5. prescribing fees for licences, for transfers of licences and for renewals of licences."

Any other comments? Shall the amendment carry? Carried.

Motion agreed to.

The Chairman: Mr Carrothers moves that subsection 33(1) of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding thereto the following paragraph:

"30. exempting any person who operates a health facility that is approved, licensed or designated under any other act or any class of such persons from the application of this act by the regulations or any provision thereof."

Any discussion? Shall the amendment carry? All those in favour? Opposed? It is carried.

Motion agreed to.

Section 34:

The Chairman: Mr Carrothers moves that section 34 of the bill, as set out in the reprint to show amendments proposed by the Minister of Health, be amended by adding the following subsection:

"(2) Section 51 of the said act is amended by adding thereto the following subsection:

"(4) The Lieutenant Governor in Council may make regulations under clause (1)(j) prescribing services that are insured services without prescribing any amounts payable by the plan for those services."

Mr Carrothers: Mr. Chairman, this is health-speak, and I believe it is a technical amendment to make it very clear that the Health Insurance Act can be amended and that perhaps fees can be paid under that act that are not necessarily fee for service. So, it is expanding the flexibility and it is a complementary amendment to things we have done earlier this week.

Mr Eves: I would just ask the ministry to explain why they require this amendment.

Mr Sharpe: The concern here is a technical one that the thrust of the Health Insurance Act seems to be one of fee for service. There is a schedule of benefits. It includes physicians and some nonphysicians, but there was some question as to whether we could list new groups. For example, the psychologists who came before us said that it might be seen by the ministry at some point to be important to have independent health facilities that are mental health facilities where there are no physicians. There may be clinical psychologists running them. In order to bring them under this act, they have to be able to be seen to be rendering insured services. We had to therefore be able to put them under the Health Insurance Act as practitioners but fund them under this act. So what this does is say that it is possible for us to say the services provided, for example, by clinical psychologists in independent health facilities are insured services; not provide a fee-for-service mechanism in the Health Insurance Act, but then fund them under a mechanism in this act. So we were advised by legislative counsel that this would provide the clarity and certainty we need in order to do that.



1120

Mr Reville: This amendment is a very scary one in some ways. It is kind of a two-edged sword, I feel. In one way, it will redress a structural imbalance in the way health care professionals are treated and have traditionally been treated in our systems in Canada, so that medical doctors, dentists and some chiropractic services get their hands into the pot of gold and all the rest do not.

That is the way it developed and it would be unconscionably expensive to offer the pot of gold to all 75 health care professions. In fact, probably several have been created this morning that we do not even know about yet. I learned about a new health care profession called Feldenkrais the other day, which is very irritated about the health professions legislative review. Once they described to me what it was, I could see why. You will all get to learn about it as well. It is not rolfing though. I just want you to know it is different from rolfing. You learn how to do this at an institute in California, I think.

In any event, this kind of convolution is required by the structure of our Health Insurance Act, there is no question about that. The danger—the same danger that Mr Eves is concerned about—is that those who have access to payments under the Health Insurance Act are going to be really nervous that this will be used as a tool to change those payments without their input. I think that is what the Ontario Medical Association would be concerned about. If it is not used in that way, then they will not be concerned.

This complementary amendment section was the section that caused such grief when it was initially revealed. It has been amended twice now. I think it will cause a little less concern, but there is always going to be a residual concern when the government gives itself the power to prescribe either the amount that is going to be paid for a procedure or the kinds of procedures for which payment will be made. That will always continue to be a concern for health care professionals.

All that said, I will support it.

The Chairman: Shall Mr Carrothers's amendment carry? All those in favour? Opposed?

Motion agreed to.

The Chairman: Section 35? Section 36?

Mr Reville: Let's move the whole bunch of sections right now and that solves that.

The Chairman: I was going to ask for guidance there.

Shall sections 1 through 36, as amended and as deemed to be amended in our initial motion—we have already dealt with that—carry?

Sections 1 to 36, inclusive, as amended, agreed to.

Mr Reville: Keep going, Mr. Chairman. You are doing fine.

Title agreed to.

The Chairman: Shall the bill, as amended, carry?

Interjections: No.

The Chairman: All those in favour? Opposed?

Mr Reville: I want a recorded vote on it.

The committee divided on whether the bill, as amended, should carry, which was agreed to on the following vote:

Ayes

Carrothers, Daigeler, Keyes, LeBourdais, McClelland, O'Neill.

Nays

Eves, Johnston, R. F., Reville.

Ayes 6; nays 3.

Bill, as amended, ordered to be reported.

Hon Mrs Caplan: Before we adjourn, can I make a statement? I would like to take the opportunity of thanking legislative counsel, Hansard, certainly our very fine committee chairman, all the ministry staff and officials, members of the opposition and all those who came forward and made presentations before the committee.

I participated in a number of legislative committees and I think the work that was done here resulted in the kind of bill that can be reported back to the House, which reflects the intent of the principles that were articulated, and shows how the committee process can respond to issues of concern. I would particularly like to thank everyone involved with the process which I think has been very productive. On behalf of ministry officials and myself, I want to acknowledge the hard work.

Individually, I would also like to specifically thank the Ministry of Health officials, few in number, and say that the effort they have put into providing all members of the committee with the information that they required, was far beyond the nine-to-five normal day. I was extremely impressed and proud to work with all of them. I would like to thank them personally.

To our Health law expert, Gilbert Sharpe, who actually works for the Ministry of the Attorney General, a special thanks. He is not officially a Ministry of Health employee, and I wanted to point that out.

Mr Eves: I knew there was some reason why he was very logical.

Mr Reville: It is not at all difficult for me to associate myself with the remarks made by the minister. I have found the process to be absolutely the most interesting thing I might have done with the month of August. I still do not like the bill much, but I like it a little better than I did the first time I saw it, and I have to say that I am not familiar with many occasions during majority government, when amendments have been accepted from both opposition parties. I think that is an usual occurrence and it is the sort of thing we should try to encourage around here.

I should point out that I found the assistance of legislative counsel and ministry officials to be excellent, and I want to thank them for that. The information that we asked for was forthcoming promptly and fully, and the five minutes late on the one thing, I do not think we should hold that against anybody.

I look forward to seeing this bill come back to the House, where we will have an opportunity to have another go at it.

Mr Eves: Like my colleague, Mr Reville, and the minister, I think that we have certainly improved the legislation, not only through the ministry's initial redrafting of the bill, but indeed, through the committee process. Not all, but many of the concerns that were raised by various individuals and groups that have appeared before the committee, have been somewhat addressed. I am not totally happy with the bill, but be that as it may, it is a much improved product. I think that the committee spent its time very wisely, and I think it was a very profitable exercise.

Mr Carrothers: I, too, very much enjoyed the month of August which we spent here. I think that we have been very productive. It is good to see that we can have amendments and get them accepted.

To Mr. Reville, I would say that I am sure that all reasonable amendments from the opposition will get due consideration in the future, as well as has happened this month.

Mr R. F. Johnston: What do you think, Yvonne? As vice-chairman do you think you should say a few words at this point?

Mrs O'Neill: Richard, I have been comparing this in my head with what we did with the first report of the select committee on education. I found that a really interesting experience, as I have this one.

Mr Keyes: And we will next month too, September.

The Chairman: As chairman, I would like to echo the compliments paid to everyone involved and to add my thanks to the members of the committee for their co-operation over the past several weeks. Your promptness and co-operation in all respects has been most helpful and has made my job as chairman, a lot easier.

The committee has concluded the work assigned to it by the Legislative Assembly, and will meet again once the assembly is back in session.

Mr Reville: We should probably all join hands now.

Mr Daigeler: Praise the Lord.

Mr R. F. Johnston: Or sing a round of something.

The committee adjourned at 1131.







NOV 9 1990





3 1761 1146646 4